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Cannabis bill designed to create flexible laws while discouraging use

By PETER MICHAELSON

OTTAWA—Gingerly side-stepping a growing number of claims that cannabis may be hazardous to health, the Liberal government has introduced a long-awaited bill to ease the severity of the country's cannabis laws.

Health Minister Marc Lalonde conceded that, despite discrepancies in the existing law, the bill had been given a low priority in cabinet. It was introduced in the Senate because of a heavy legislative workload facing the House of Commons, he said.

The bill, promised by the Liberals more than two years ago, is intended to make the laws more just and flexible, not to encourage cannabis use, Mr. Lalonde told a news conference.

Meanwhile, his officials were watching with interest the results of international research on the effects of cannabis smoking on health.

While possession offenders can no longer be imprisoned under the new laws (unless they default on payment of fines), people found guilty of possession will still have a criminal record and a court appearance by which to remember the occasion, the minister said.

Mr. Lalonde said the existing law "is an ass," and referred specifically to its provisions calling for a minimum seven-year minimum sentence for importers or exporters, no matter how small a

More stories—page 2

quantity of cannabis found on the offenders.

He also said police officials were unhappy with the rigidity of present laws, particularly with regard to trafficking offences.

Police don't want to prosecute small-fry offenders for trafficking, particularly teenagers caught selling a few grams of cannabis, because the present penalties are too severe, he said.

Often, the police were just laying possession charges against these clear-cut traffickers, a compromise on the police's part which put the cannabis laws in further disrepute with all sectors of society.

The bill, which might not become law until mid-winter or later, after committee study by the Senate and the Commons, will remove cannabis laws from their hard-drug association in the Narcotic Control Act and place them in the Food and Drugs Act with the presumably less dangerous

(See —long-awaited—page 2)

Synanon—"a communal training school for a new social order"—Page 4

'Lifestyles' place unborn babies at risk

By BETTY LOU LEE

HAMILTON — Any pregnant woman who is a chronic user of illicit drugs—even marijuana—is a high-risk pregnancy, says Dr. James E. Anderson, a consultant to the LeDain Commission.

Dr. Anderson, professor of anatomy at McMaster University, said direct effects of specific drugs on the fetus are not known, but the lifestyle of the chronic user is apt to endanger the baby even if the drugs themselves do not.

He was speaking at an annual refresher course in obstetrics and gynecology held at Henderson General Hospital.

"With infrequent or intermittent use of marijuana or hashish, there is no evidence they are going to confuse their life or yours," he told an audience of family physicians.

"But daily use involves a lifestyle that is not compatible with good motherhood. Soft drugs are as much of a threat to pregnancy as hard drugs.

"All drug-using females are high risk pregnancies. They have a higher risk of infection, especially with hepatitis. They have a higher rate of malnutrition, particularly a lack of protein. Their self-care is bad. They make few pre-natal visits, and if they are hard drug users, often their first visit is when they come for delivery.

"All daily users, including cannabis users, have a higher rate of prematurity, low birth weight, congenital defects, stillbirth and spontaneous abortion."

He said all women who have had no prenatal visits but arrive for delivery should be assumed to be narcotic addicts until proven otherwise.

Illustrating the dearth of valid information on the effects of illicit drugs on reproduction, Dr. Anderson said 18 months ago a survey of 100 papers devoted to LSD and defective chromosomes of children showed they split 50-50 in results.

"It's embarassing to say a great deal of the results depend on the social bias or ineptitude of the investigator. In the inept area.

(See—unborn—page 12)

Addicts' blood harms surgery patients

HOUSTON—About 20% of open-heart surgery patients in Germany have developed hepatitis after their operations because of the decline in volunteer blood donors, and the need to buy commercial blood.

"The problem is that so many of the commercial blood donors are drug addicts, who have a high incidence of hepatitis". Dr. Mrid Wende told The Journal.

"They're the ones who sell their blood because they have a desperate need for money."

Dr. Wende, a cardiologist at St. Georg Hospital in Hamburg, added, however, that cardiac surgeons are now trying "a new tack" to eliminate the problem of addicts' blood.

"If we know a patient will need surgery, we draw blood from him or her as much as a year before, and then freeze it for use later on. This amount will be enough to provide the half-litre or litre of blood needed to get the heart-lung machine going.

"Other than that, we've had to use saline to avoid the hepatitis problem. But then, patients don't recover as fast. Of course, they don't recover as fast, either, if they get hepatitis."

Dr. Wende described the heroin addiction problem in Germany as "still serious, but it seems to be declining".

He was interviewed here while visiting open-heart surgery facilities at the University of Texas Medical Center.

Breast growth for male pot smokers

By TOM W. HILL

MIAMI—New evidence that chronic use of marijuana affects male reproductive physiology was revealed here at the 60th annual clinical congress of the American College of Surgeons.

Dr. John W. Harmon and Dr. Menelaos A. Aliapoulios, surgeons at Harvard Medical School and Cambridge Hospital, Boston, reported on 16 young men—all fairly heavy marijuana smokers—who developed the embarrassing and often painful condition called gynecomastia.

In this condition the male breast becomes enlarged and resembles a female breast.

The surgeons took detailed histories and performed comprehensive physical examinations and laboratory tests on several of these individuals, to rule out other possible causes of their breast enlargement.

They also did animal studies to try to demonstrate a cause-and-effect relationship between marijuana and the proliferation of breast tissue. The animal studies appear to have confirmed that marijuana is the causative agent.

Some other drugs are known to cause gynecomastia, Dr. Harmon noted. These include digitalis, employed in treating certain heart conditions; reserpine, which lowers blood pressure and acts as a tranquilizer; and the widely-used class of drugs called phenothiazines, administered for a variety of conditions from nausea and vomiting to mental illness.

Tumors of the adrenals or of the brain or testes can also cause male breast enlargement. So, sometimes, can liver disease.

Physicians are generally aware of these possible causes, Dr. Harmon told The Journal. But very few realize marijuana can have this effect. Thus it is possible that many cases have gone unreported to date.

He told of one young patient with much enlarged breasts who was seen in "a large university hospital in another city".

Physicians gave the young man a thorough examination finally diagnosing the condition as "idiopathic gynecomastia," i.e., gynecomastia of unknown origin. They

(See—Male—page 2)

...INSIDE THE JOURNAL

Senate committee prepares to debate cannabis issue

OTTAWA—"The use of soft drugs leads almost inevitably to the use of hard drugs. . . . Furthermore, I am in favor of the death penalty for heroin traffickers."

With that, Senator Joseph Sullivan, a medical specialist and one of four Canadians belonging to the Royal Society of Medicine, launched the first Senate opposition speech to the Liberal government's cannabis bill.

Tough as his speech was, he said later in an interview he is "not vehemently opposed to the bill," recognizing that it's primary intent is to correct discrepancies in the law.

What the Conservative senator did object to was the implication contained in a lessening of cannabis penalties that the drug is probably not all that harmful. Senator Sullivan, a former chief consultant in otolaryngology to the armed forces, is convinced the drug is mentally and physically harmful.

The bill is expected to go the Justice and Legal Affairs Committee of the Senate for detailed study in January following the Christmas recess. Chairman of the committee is Senator Carl Goldenberg, the eminent authority on labor and taxation issues.

Senator Joan Neiman, the Ontario Liberal who sponsored the bill, said in an interview with **The Journal** that she believes the bill will not create the furor some observers predicted.

There was initially some misunderstanding about the bill; some senators had grumbled that it would make drugs available to anyone who wanted them, she said.

Since her Senate speech, however, in which she emphasized that the entire thrust of the bill is to imbue the cannabis laws with more justice, several senators have told her they see the issue in a new perspective.

However, that doesn't mean they'll vote for the bill, said Senator Neiman, noting that several senators in both Liberal and Conservative ranks have strong reservations about any changes to do with a softening attitude to drugs.

Joseph A. Sullivan

The bill will go back to the Senate for third and final reading, and then will be re-introduced in the House of Commons where it will be scrutinized in committee.

Although some MPs, like Liberal Simma Holt of British Columbia where most of the country's hard-core addicts reside, have lobbied for a free vote on the bill, it is expected to be voted on along party lines and to pass easily with the Liberal majorities in both houses.

The only question is when the law will come into force, and with what amendments. If Commons opposition stalls the bill in committee, it may not be passed until mid-winter or later.

Moreover at least one parliamentarian, Senator Sullivan, says he will propose amendments to the bill in committee.

The Senate committee wants to hear from the commissioners of the five-member LeDain Royal Commission on non-medical drug use, including chairman of the commission, law professor Gerald LeDain of Toronto. The commission spent about $4 million in a four-year study of illicit drugs.

Joan Neiman

Senator Neiman said she hoped commission members would have new information for the committee since the commission's final report was published in December, 1973.

She said the committee is also particularly interested in hearing from police officers and members of the judiciary who will be most affected by the legislative changes.

There were early indications that deputations for and against would appear at the committee, "but now I don't believe there'll be that many" because of an apparent lack of opposition to the bill.

Senator Sullivan said in his speech that drug abuse is indicative of moral degeneracy.

Long-awaited cannabis bill introduced

(continued from page 1)

controlled and restricted drugs, including LSD.

Whatever Mr. Lalonde may think of the need to correct discrepancies in the present law, he apparently remains convinced cannabis possession should not be legalized.

"The weight of evidence led us to apply a restrictive approach, in order to discourage both the use and the sale" of cannabis, he said.

The penalties are still harsher than those proposed by the LeDain Royal Commission into the non-medical use of drugs, which recommended in a 1972 majority report that simple possession be made legal. Only one of two minority reports suggested penalties—a $25 fine for a first offence and $100 for subsequent offences.

Mr. Lalonde said the commission's final report, published in December, 1973, appears to suggest cannabis use may be more harmful than the commission suspected in earlier reports.

A main feature of the bill is the freedom of choice it offers courts in the method of prosecution.

At present, all offences except for possession result in criminal proceedings by indictment, which is a more formal and lengthy court proceeding usually followed on conviction by a prison term.

Under the new law, prosecutors would have the choice of proceeding by summary conviction (which often draws only a fine) or indictment for all offences except simple possession. For this the prosecutor is limited to a summary conviction.

Now, said Mr. Lalonde, the small-fry trafficker could be charged with trafficking and a summary conviction might only produce a small fine, an appropriate penalty in some circumstances.

Meanwhile, courts still had the option of proceeding by way of indictment in order to impose stiff penalties on organized criminals.

J. E. Hodges, a justice department lawyer who worked on the new legislation, says the new laws for possession offences probably will not make much difference from current practices in the courts.

However, it is likely the flexibility of the new laws for the more serious offences will mean a greater change from current practices in that area, he said.

The courts have been more lenient with possession offences in the last three or four years, influenced first by the 1970 LeDain report which recommended fines of no more than $100 for cannabis possession and, second, by the promise of then Health Minister John Munro in 1972 to change the cannabis laws.

Opening debate on second reading of the bill, Senator Joan Neiman, an Ontario Liberal who sponsored the bill in the Senate, produced statistics to show possession offenders seldom receive jail terms under current procedures.

In Canada in 1973, there were 18,603 convictions for simple possession of cannabis, she said. Courts imposed fines in roughly 71% of the cases.

The courts also made use of provisions regarding probation, absolute discharge and conditional discharge in some 4,500 cases, leaving less than 1,000 who went to jail.

Mr. Hodges said some of these, such as visitors to Canada without money for fines, may only have been given one-day jail sentences "which consists of taking their fingerprints and letting them go".

Senator Neiman also noted there were 19,929 convictions for more serious cannabis offences in 1973, compared with 1,500 convictions for other offences under the Narcotics Control Act involving such drugs as heroin.

Mr. Hodges said the average sentence for cannabis trafficking in Ontario ranges from three to six months, and ranges as high as 10 to 18 months in some other provinces.

He suspected these averages would come down under the new laws but would not further predict the courts' attitude or reaction to the legislation.

On another matter, Senator Neiman told the Senate the legislation "will not in any way derogate from Canada's international obligations on domestic commitments with respect to cannabis".

As a signatory to the 1961 Single Convention on Narcotic Drugs, Canada recognizes the obligation to control cannabis and other drugs from domestic and international standpoints, she said.

She also indicated the frustrations facing the government in its attempts to come to terms with drug abuse.

"The simple truth (about cannabis) is that as yet there is no simple truth, and we are left with the problem of formulating legislation that will make sense in an area where challenge, contradiction, and refutation seem to be occurring in the scientific community."

Male pot smokers develop breasts

(continued from page 1)

operated on the breasts to remove excess tissue.

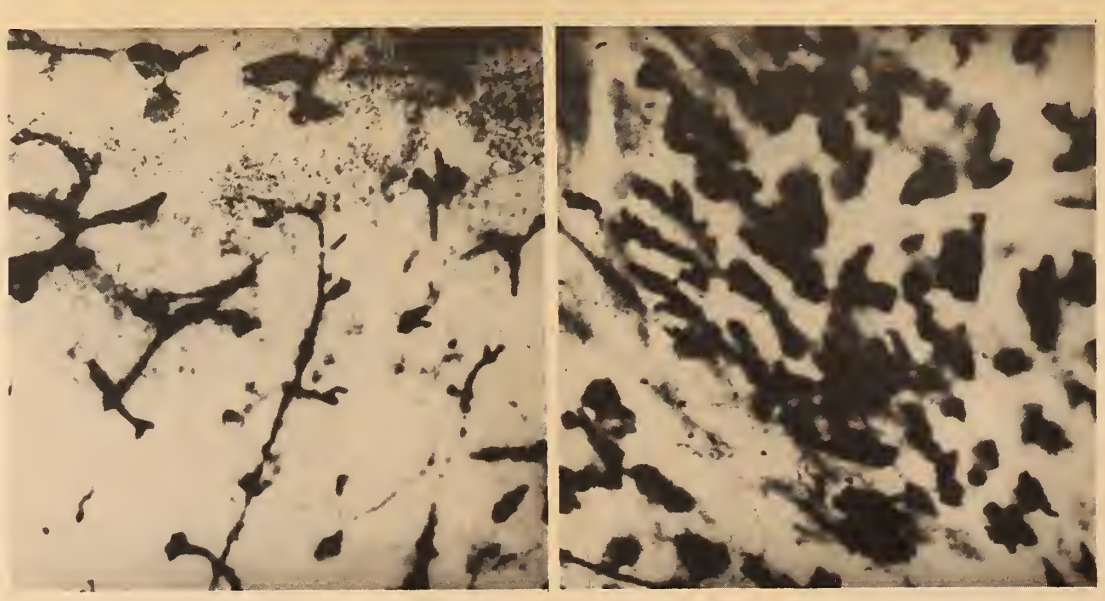
The youth had been smoking marijuana for two years and continued to do so. His breasts continued to grow. When he was finally seen at Cambridge Hospital, he had to have surgery again.

"Clearly a dramatic case of very highly stimulated breast," said Dr. Harmon. This patient has not been followed long enough to find out whether the growth has been arrested. He claims to have stopped smoking marijuana now.

Not all young men who develop the condition have such massive breast development. One college student, who smokes heavily at college but stops in the summer when he is at home with his parents, has reported that his moderately enlarged breasts become quite tender when he is smoking but the tenderness goes away when he is abstaining.

One problem in studying the phenomenon is that some young men who develop gynecomastia will not voluntarily report their condition—partly from embarrassment, says Dr. Harmon, and partly because of the legal problems in admitting marijuana use.

Of the 16 cases Drs. Harmon and Aliapoulios are aware of, they have been able to study only seven in detail. Four of the seven had breast tissue removed surgically on request. The other three stopped using marijuana and report some reduction in both breast size and tenderness as a result.



Photomicrographs of breast tissue of rats show control rat (left) and with THC administered (right)

In the animal experiments the Harvard surgeons injected male laboratory rats with delta-9-tetrahydrocannabinol (THC), the psychoactive ingredient of marijuana. They also injected an equal number of rats with a control solution. Injections were given daily for periods of from 13 to 21 days.

Specimens of their breast tissue were then examined in a blind manner, i.e. researchers evaluating the proliferation of breast tissue were not aware of which animals had been injected with THC and which with the control solution.

They evaluated the proliferation by means of a grading system (Grades I to IV) based on the density of the small ducts visible in the tissue. An immature rat will have just a few branches, but a lactating rat has a dense network.

"The type of proliferation that we were looking at lies between these extremes," Dr. Harmon told **The Journal**.

"The growth occurs at the ends of the ductules and you can see a budding. In Grade I there are just a few branches with perhaps a few buds. In Grade II they are a bit more dense and so on to Grade IV."

The rats injected with THC had significantly more proliferation of breast ductules than control animals, the researchers found.

"Having the animal data to back up our human findings shows rather clearly that marijuana does indeed stimulate the breast," Dr. Harmon noted, "but you couldn't say it's 100% proven until some other lab confirms it."

Other research also suggests chronic marijuana use affects male reproductive physiology. Dr. Robert C. Kolodny and co-workers at the Reproductive Biology Research Foundation and the Missouri Clinical and Biochemical Laboratory, St. Louis, Missouri, found that men who used marijuana at least four days per week for a minimum of six months had lower levels of the male hormone, testosterone, in their blood than men who did not use the drug.

Dr. Kolodny also found that the testosterone level was "dose related," i.e., the heavier the smoking, the lower the plasma testosterone.

NIDA research chief

Marijuana: 'Like coffee, heroin, or DES ?'

By REX RHEIN

THE HEAD of the U.S. government's drug-abuse research program says the important questions about marijuana are only now being asked, much less answered.

Dr. William Pollin, director of the National Institute on Drug Abuse's Division of Research, has a background himself as an investigator of mental illness, having collaborated on many of the landmark studies on schizophrenia in twins that appeared in the American Journal of Psychiatry in 1971.

In a wide-ranging interview on past, present, and future marijuana studies, he said "some of the most important questions still remain unanswered".

Only recently, in fact, have some of them been asked. For example, it is "impossible to answer whether chronic use of marijuana leads to amotivational syndrome because of design difficulties in present studies," the 52-year-old psychiatrist said.

"Amotivational syndrome" is the frequently observed—but almost unmeasurable—lack of

Dr. Pollin

Heavy Smokers

motivation that has been attributed to heavy smokers of pot. A well-designed study, Dr. Pollin said, would follow matched groups of users and non-users through a period lengthy-enough to draw valid conclusions about the effect of the drug on their life achievements.

Current studies along this line, he said, are not producing the expected results. But the very process of matching users and non-users may throw the validity of the studies into question.

The best "controlled study," currently underway in Costa Rica, is about a year from completion. It selected 40 users from 160 heavy marijuana smokers and 40 non-users from a sample of 80. Subjects and controls were matched to reflect socio-economic status, age, sex and educational background.

"But if a person demonstrates the motivation to get into college, for example, picking him for the study at that point throws the results off."

The same thing would be true about the "lack of motivation" of a person chosen because of his low socio-economic or educational status.

Dr. Pollin says the ideal prospective study of amotivational syndrome would follow a very large group of people (perhaps

Childhood

several thousand) from childhood through at least early adulthood, with "matched" subjects and controls chosen at random, prior to any marijuana use.

Naturally, only a small percentage of the chosen "subjects" would actually become subjects—those who, in fact, began using marijuana. And any "controls" that began using the drug would have to be rejected. Because of both these rejections, only a few hundred people, at most, would actually be followed to the end.

Such "cohort" studies of some 15,000 grade-school children are just now getting underway in Boston, he said. "But it will be a long time before they will show any results." At the same time, there is a "tremendous concern over maintaining confidentiality".

Amotivational syndrome is perhaps the one effect of chronic marijuana use that will ultimately determine the drug's legal status. Despite recent reports that the drug may be responsible for chromosome breakage, DNA synthesis retardation, testosterone inhibition, and even abnormal breast development, the telling legal argument for its continued prohibition may well be its adverse effect on society as a whole.

Otherwise, it invariably will be compared with alcohol and tobacco—or aspirin and coffee—and be found, if anything, merely a comparably unhealthy vice.

Dr. Pollin is acutely aware of the hot controversy over each scientific finding reported by researchers his program supports. Investigators themselves are "troubled by whether their findings will be used in legal issues," he says. It's a fact of life he has learned to live with.

"Even when dealing with medical issues with no overlay—such as oral hypoglycemic agents (antidiabetes drugs)—there is tremendous controversy," he says. "Physicians were at each others' throats as to whether these agents are a help or a danger to their patients.

"In the case of marijuana, everything is complicated by the fact the drug has become a symbol of hotly-debated issues in this country."

An historical parallel Dr. Pollin sees with the current debate is "when coffee was introduced to Europe from the Middle East, it was thought to have very dangerous effects on behavior."

For one thing, coffee houses were then a hotbed of radicalism, he noted. "I've even heard its use was punishable by death.

"My own feeling about marijuana is that, though there has been a burst of very productive research, we still don't know whether it's like coffee, or like heroin (which was thought to be a safe treatment of morphine addiction), or like diethylstilbestrol (which was thought to be safe for pregnant women).

"We hadn't realized until recently what the essential questions are. For example, there is a strong suggestion marijuana in high dose levels depresses testosterone, or perhaps even the equiv-

Hormone

alent female hormone (that study hasn't been done yet).

"This ties in with isolated reports that it produces enlarged breasts in the male. So it seems as if marijuana is related to hormonal imbalance.

"The question is, what happens if marijuana reduces testosterone levels—not in adults, but right around puberty? This is a particularly relevant question because data from San Mateo County (Calif.) shows that the 7th Grade use has increased more than 100% in males between 1968 and 1974. At age 13, now 22% have used marijuana."

Dr. Pollin does not believe an ethical study of the effect of marijuana on juveniles is feasible in the U.S., even though the knowledge is vital to informed public policy.

Foreign studies are a possibility, although the same ethical problems would remain. Retrospective studies are always open to question, and epidemiological studies involving thousands of people are long and costly.

There are other questions that arise from knowledge generated from previous studies, Dr. Pollin continued.

One of the latest findings, he said, is that in some areas marijuana has "biphasic action"—that is, like some of the barbiturates, it acts as a stimulant or a depressant at different dose levels. "This may be the reason why so many reports have been confusing in some areas," he said.

One most intriguing finding from current research, he said, is that there is some evidence marijuana may actually be addictive to some people.

"Most workers feel it's not an addiction like heroin or cigarettes, where a large majority who use these can't control the use. We think there is some addiction, but we're not sure how extensive it is."

A surprising finding from the national reporting system of U.S. addiction treatment centers has been that between 12% and 15% of addicts say their prime drug of abuse is marijuana.

"I'm sure it's an inflated figure," Dr. Pollin says. "Many of these people are in the centers only because they were sent there by judges or their families. We're sure it's closer to 2%."

Even a 2% addiction rate is noteworthy, however. Current popular wisdom holds that marijuana is not at all addictive. Dr. Pollin explains that these marijuana "addicts" are heavy users who demonstrate irritability and sleeplessness when denied the drug.

"It's been shown in humans by at least one or two researchers," he said. "It's an analogous but much weaker process than heroin addiction."

Dr. Pollin said it is important that marijuana researchers report negative findings as well as positive results. Scientists in general have a tendency to keep their negative results to themselves, he said. "One of their most important jobs is to replicate, document or disprove other researchers' findings.

"At the same time, we must begin looking at a larger set of questions more difficult to study. How do you find out, without retrospective distortions, the

Addictive

effect of marijuana use on adolescent development? Perhaps the addictive process itself may be more important to study than any particular drug."

Besides marijuana research—which gets about $5 million a year from the U.S. government—the bulk of the program's $32 million of research money ($15 million to $20 million) goes into study of heroin addiction and projects all over the world, including three large private clinical centers and the U.S. government's own addiction research center at Lexington, Ky.

Teenagers are using more cannabis and alcohol but 'chemical revolution' is waning: ARF study

By ANNE MACLENNAN

THE POSSIBILITY that parents are actually assisting trend-setting advertisers and encouraging increased alcohol use by their children has been raised by a new study.

Indeed, liberal reaction to the prohibition mentality may have gone too far and some sort of countermovement back to "middle ground" may be called for, one of the study's authors told **The Journal.**

While it may be valuable for children to be taught how to drink in their own homes, said researcher Dianne Fejer, it should probably be a matter more of "satisfying curiosity" than giving the impression drinking by children is acceptable.

For example, she said, emphasis might more wisely be put on "allowing say a 16-year-old a taste of wine" rather than on allowing him or her a glass of wine with meals even if infrequently.

The study by the Addiction Research Foundation is the fourth in a series of cross-sectional trend surveys of student drug use begun in 1968 and repeated at two year intervals since then. It is one of the few long-term studies in the English language of drug use among young people. Co-author, with Ms Fejer, is Dr Reginald Smart.

Findings indicate the chemical revolution of the late 1960s "seems to be waning" and that use of most, dangerous illicit drugs has declined since 1970 when it peaked.

However, use of alcohol and marijuana has increased consistently and significantly over the past six years.

Women are also gaining a dubious "equality" in the area of drug use, according to the report.

In 1968, and even in 1972, use of many drugs was largely a male-dominated activity.

"In 1974, it could no longer be said that drug use is more common among males than females," says the report.

As for alcohol, the percentage of students reporting use "at least once in the past six months" has jumped to 72.9% in 1974 from 46.3% in 1968 (70.6% in 1972).

Asked for the first time ever how much of their alcohol consumption was in the form of taking wine with their families, more than 42% said all or almost all drinking was done in this setting.

This "illustrates a widespread permissiveness regarding alcohol consumption by parents for their children, many of whom would be under the legal drinking age," says the report.

The "most encouraging change" to take place between 1972 and 1974, it says, involved tobacco.

Smoking declined in those two years by five per cent to 33.7%, the lowest rate in surveys to date However, this was also the area of "most notable change" in sex pattern of drug abuse.

In 1968 and 1970, males smoked tobacco significantly more often than females. There was no difference between the groups in 1972 but, in 1974, 34.8% of females smoked tobacco compared to 32.6% of males.

Females were also found to use barbiturates and tranquillizers more often than males although males continue to use alcohol, marijuana, and LSD more often than females.

Marijuana use showed a considerable increase in the six years, with 22.9% reporting use in 1974 as opposed to 6.7% in 1968.

Although the students surveyed (3,479) were in Metropolitan Toronto, results are markedly similar to those obtained in a study by San Mateo County Department of Public Health and Welfare in California between 1968 and 1974.

That study also showed a consistent increase in alcohol and marijuana use but a levelling off of most other drug use since 1968.

Pot-smoking adults on increase

DESPITE A growing body of evidence suggesting cannabis smoking may be a health hazard, there has been a marked increase in its use by adults in the past three years.

This is the chief conclusion of a two-part survey of adult cannabis use in Metropolitan Toronto, one of Canada's largest cities, conducted in 1971 and then again in 1974.

It shows that 47.6% of adults aged 18 to 24 years, particularly males, used cannabis in the past year in contrast to the 29.7% who reported having used it in 1971.

The highest proportional increase, however, was in the 25 years and older group in which the 3.3% who reported use in 1971 increased to 7.5% in 1974.

In 1974, about 44% of single people (27% in 1971), and 7% of married people used cannabis. Its use among housewives (3%), retired people (0%), and people working full-time (13%), is relatively infrequent.

Use appears most frequently, says the report, among students (57%), and people working part-time (29%).

Although use was preponderant among males, the proportion of male adults using on seven or more occasions in 1974 was less than in 1971, with 62.3% reporting such use then and only about a third of those surveyed reporting such use now.

In contrast, nearly half of all female users now report cannabis use seven times or more in 1974 whereas in 1971 only 32.5% reported such use.

Co-authors, Drs. Reginald Smart and Michael Goodstadt, and Marion Gilles, Addiction Research Foundation, stress that results should be viewed in the context that in 1971, 1,200 people were surveyed whereas the 1974 sample (347) was much smaller.

SYNANON: 'Pathway to a new society'

By SAUL ABEL

SANTA MONICA, CAL.—The grand-daddy of therapeutic communities for drug addicts—Synanon—is taking on a new image, with increasing emphasis on educational functions.

Developments like its "rotten kid" program, and a research study of its nursery school children, reflect the role of the Synanon Foundation as a kind of communal training school for a new social order.

Convinced that juvenile delinquency, drug addiction, and alienation are no longer just problems of the ghetto, but as much or more problems of the middle class and the affluent, Synanon has gone into the "rotten kid" business, organizing a "core group" of some 25 youth, aged 12 to 17 years in a special "education" program.

These are problem children—rebellious, delinquent, pre-addicts. They come from parents, from the courts, from various institutions. In their own peer group, they will be introduced to the Synanon approach of reversed role models.

Their "hero" will be the honest, responsible member of their "society", not the hoodlum, the punk, the addict or the gangster. Put to the acid test will be the Synanon thesis that good behavior precedes and fosters emotional change; act as if you're an adult, and eventually you'll become an adult.

The nursery school, a children's community within the larger Synanon community, is a natural laboratory for the study of human development. A research study of the social structure and behavior of peer groups of communally-reared children up to four years of age, is now in progress at Synanon, funded by a grant from the National Institutes of Health.

These facts highlighted an interview by **The Journal** with a "panel" from Synanon House in Santa Monica. The panel included Russell Mumford, coordinator, Michael Kaiser, public relations director; Louis Delgado, director of visual communications and graphics; and Bernard Kolb, director of public safety.

They represent a cross-section of Synanon membership. Kolb and Delgado are ex-addicts or, as Synanon terms them, "dope fiends", and have lived "clean" in Synanon for eight and 10 years, respectively.

Mumford and Kaiser are "squares" who joined the Synanon community for its alternate lifestyle. Mumford, a resident for more than seven years, was a stockbroker. Kaiser, a resident for more than nine, was an advertising man, and now operates his own agency "outside".

Lifestylers like Mumford and Kaiser make up almost half of the more than 1,300 Synanon population at four California residences: Santa Monica, Oakland, Tomales Bay and Badger. The foundation also owns apartment houses, and there are Synanon branches in Detroit and New York City, operating primarily as intake services for screening applicants.

These are not "ghetto houses". The Oakland and Santa Monica residences were formerly exclusive private clubs. The Tomales Bay site is a 3,500-acre ranch, graced by a once-palatial mansion built to lure Italian physicist and radio inventor Guglielmo Marconi to the United States during World War I.

Synanon began in 1958, financed by a $33 unemployment insurance cheque of founder and guiding spirit Charles E. "Chuck" Dederich, now chairman of the board of regents.

From the start, Synanon has maintained it is a pathway to a new way of life, even a new kind of society, and that its remarkable record in curing and rehabilitating addicts is just a side effect.

Viewed in this light, Synanon's new educational image represents not so much a transformation as a recognition of what Synanon has always been, and is now.

Traditionally, Synanon has seen itself, and often has been described, as a school, a learning environment. The very name, Synanon, was coined by an early resident, a malapropism combining "seminar" and "symposium."

The approach of a total learning environment has had singular success against the hitherto almost insoluble character problems of addiction. More than half of those who enter Synanon stay more than three months; of these, almost 90% are "clean."

Former Synanon medical director, Dr. Karl J. Deissler, has said therapeutic communities on the Synanon model offer the best, and perhaps the only, hope of solution to the "epidemic" of drug addiction (**The Journal**, May 1973).

The model has been widely copied or adapted by agencies not only in America, but in Europe and Asia as well.

There are three cardinal rules at Synanon. Two—no drugs and no violence—have been in effect from the beginning. The third—no smoking—was established about four years ago.

Violations may be grounds for expulsion. Contrary to gang ethics that consider "squealing" or "ratting" a heinous offence, at Synanon, informing on anyone whose behavior is harmful to himself or the group is not only condoned but encouraged.

Addicts entering Synanon, including some who have been on heroin since they were 12 years old, kick their habit "cold turkey", with plenty of human warmth for support, but no artificial or chemical "crutches".

Everybody at Synanon works, and there is complete mobility in job opportunities from scrubbing floors and washing dishes to coordinators and top administrative staff. All are paid "walking around" money of a few dollars a week. They live in "tribes" of 50 to a 100 residents. There are many cultural and recreational activities in a society that is self-contained, yet involved in constant interchange with the outside world.

Synanon is a multi-million dollar enterprise, maintained by a combination of financial resources—Synanon industries such as automobile service stations and an advertising specialty business; lifestylers who contribute their outside earnings; and donated goods and services ceaselessly "hustled" by residents. Each contributes about one-third of Synanon's income.

Dederich has stated: "We are more of an educational enterprise than a therapeutic one, more of a learning process than a therapeutic process; we don't presuppose sickness as much as we presume stupidity."

Accordingly, Synanon addresses itself to the problem of ignorance through a process of mutual self-education. It is not a community of students or teachers, but rather a community of scholars, each learning and teaching at the same time. There are echoes here of Jacob Moreno's definition of a total therapeutic community, where "everyone is a therapist, and at the same time a patient, to everyone else".

Often quoted at Synanon is Dederich's dictum: "A learned man is dead, but a learning man is alive."

The Synanon philosophy concludes: "No one can force a person toward permanent and creative learning. He will learn only if he wills to. Learning is possible in an environment that provides information, the setting, materials, resources, and by his being there. God helps those who help themselves."

The reference to God may appear incongruous in the tough, secular Synanon setting, but there is an almost holy dedication, a kind of religious fervor, that animates this community. And Synanon's roots are not totally irreligious.

Synanon grew out of Chuck Dederich's participation in Alcoholics Anonymous in the late 1950s. AA stemmed from Frank Buchman's Oxford Group in the late 30s, and has a strong religious orientation.

Dederich and his first small group of drug addicts, however, soon broke away from AA, and whatever religion there is at Synanon today is religion with a small "r".

There is little stress on Christianity, or indeed, on God, except as God resides in every individual.. The emphasis is on complete honesty and self-reliance in the Emersonian tradition of individual responsibility.

These tenets are reflected in Synanon's philosophy, in its prayer, and in its game. The prayer, a daily ritual, is addressed by the person to himself, and asks these things:

"Please let me first and always examine myself;
Let me be honest and truthful;
Let me seek and assume responsibility;
Let me understand rather than be understood;
Let me trust and have faith in myself and my fellow man;
Let me love rather than be loved;
Let me give rather than receive."

These are the values lived, not merely preached, at Synanon; absolute honesty, personal responsibility, cooperation and love. In a reversal of the value system of outside society, peer group pressures are used to build a community of "moral heroes", good citizens who are totally involved.

The Synanon game, a prime tool in the search for truth and understanding, is a special form of group interaction central to the entire program.

Originally, it was a harsh, even brutal, technique, described as "a leaderless group encounter for creation of aggressive and provocative interchange, using weapons of ridicule, cross-examination and hostile attack."

Mellowed somewhat now, the game can still be abrasive and penetrating, and it is undeniably effective. It is played at least once a week, and more commonly two or three times, by everyone in Synanon; newcomer, officer, lifestyler or dope fiend. Even children, four years and beyond, play the game.

It usually runs from two to three hours, but most residents play a 12-hour game once a month. There are occasional marathon sessions of 24 to 48 hours, and a fantastic continuous game called the perpetual "stew" that goes on day and night without interruption while individual players come and go.

The balanced "mix" of game players is a living testimonial to Synanon's total lack of prejudice. Men and women of all ages, races, religions, and walks of life, play on equal footing. There is no director or leader, though more experienced players serve to guide the course of the session when necessary. No physical violence is permitted, but verbally "anything goes".

Dederich says the game "can accomplish a unification and healing of the personality, an appreciation and acceptance of new and more constructive forms of behavior, and the adoption of new and sounder value systems; it is a therapeutic experience, and most residents with character-disordered backgrounds believe it has saved their lives."

The game is a potent educational tool underpinning Synanon's growing diversity of "schools within a school". It was necessary very early to organize a nursery school, because many residents brought small children with them, and others gave birth to children while living at Synanon.

The nursery children do not live with their parents. They are taught and cared for in the communal style of some primitive societies or the Israeli "kibbutz".

There is ample opportunity for parents to spend time with their children, and the change from the conventional "nuclear" family does not appear to have a damaging effect. The children are bright, lively and happy.

The ultimate Synanon goal is an educational complex extending from nursery school to college and beyond. Already the system is expanding to accommodate teenaged addicts and "dropouts", and normal children whose parents believe in the Synanon school.

As for evaluation, the Synanon approach is simple. The foundation is successful for people who stay there and off drugs. For those who don't, it isn't.

Said one resident: The fact that hundreds of agencies are modelled after Synanon "tells us all we need to know about whether or not we work".

The Synanon vision may seem Utopian, and history is littered with the debris of many Utopias. Still, if children are truly the "wave of the future", Synanon may be riding the crest of that wave.

Synanon House - Santa Monica

Benefits of clean air threatened by smoking

By ASHLEY McCONNELL

LONDON—The positive health benefits produced by the anti-pollution Clean Air Act in Britain are threatened by the increase in smoking, especially among the young.

This is the gloomy picture painted by Dr. D. D. Reid, Professor of Epidemiology, London School of Hygiene and Tropical Medicine, and a pioneer in research on respiratory diseases.

The Clean Air Act was brought into force following studies which showed that the foul smog in the winter of 1952 was responsible for the deaths of 4,000 to 5,000 people, mainly elderly. Strict controls were placed on open fires and coal burning.

Based on his studies here, and in collaboration with scientists in North America and Europe, Professor Reid said the major factor involved in bronchitis and emphysema is smoking.

"In whatever country you do your studies, smoking is clearly related to the production of phlegm and is obviously very important in the evolution of the disease. In the old days pollution complicated the disease and increased the risk of premature disablement."

In his latest research, based on 3,889 people who are part of a larger group followed since birth in 1946, one of the major findings is that children with respiratory illness in youth are, as adults, beginning to have chest symptoms.

Professor Reid said the evidence points to the fact that many people may have a potential liability on contracting bronchitis but that if they do not smoke they might diminish the chances.

Unless the increased trend in smoking abates, Professor Reid believes that disease rates, especially among blue collar workers, will continue to rise.

Professor Reid said the Clean Air Act was the result of Parliament's acting for the common good and with the agreement of the majority. Smoking is a personal act and, in a democratic country, cannot be legislated against.

The positive medical benefits of the Clean Air Act have been found in a recent study by Dr. Peter Howard, of the Department of Medicine at the University of Sheffield.

He examined patients with established bronchitis attending a hospital outpatient clinic firstly during a period when atmospheric pollution had just started to decline, and then again six years later.

The results, although he said they are not yet conclusive, indicate that the rate of deterioration of the disease can be reduced or arrested and, in some cases, reversed.

Dr. Howard said that those who smoke produce more sputum from the chest, have more chest illnesses more often, and have more rapid deterioration of lung function.

"The severity of symptoms is related to the number of cigarettes smoked."

Lung cancer will kill 17,600 U.S. women in '75

WASHINGTON—The National Cancer Advisory Board's annual report calls for federal regulation of tar and nicotine content in cigarettes.

The board, which includes 24 scientists, physicians and public figures, says in the report, that "cigarette smoking remains the most remediable cause of cancer deaths in the United States—and the one which seems hardest to change.

"While there is at present no way to declare any cigarette safe, it should be possible to deny those cigarettes which are obviously high in nicotine and tar access to interstate commerce and, thereby, discourage their manufacture," it says.

Meanwhile, according to new data from the American Cancer Society, lung cancer has become the third leading cancer killer of women in the U.S.

The ACS attributes this increase in female lung cancer deaths to the fact that, in the last 30 years, there has been a steady and substantial increase in cigarette smoking among women.

The lung cancer death rate for women has doubled in the last 10 years, the society says. This year, the disease will claim the lives of an estimated 17,600 American women, 2,100 more than were expected to die of lung cancer in 1974.

Lung cancer remains more common among men, who began much earlier to smoke in greater numbers than women. As the leading cancer killer among American men, lung cancer will kill an estimated 63,500 males this year.

WHAT KIND OF SMOKER ARE YOU?

	always	frequently	occasionally	seldom	never
A. I smoke cigarettes in order to keep myself from slowing down.	5	4	3	2	1
B. Handling a cigarette is part of the enjoyment of smoking it.	5	4	3	2	1
C. Smoking cigarettes is pleasant and relaxing.	5	4	3	2	1
D. I light up a cigarette when I feel angry about something.	5	4	3	2	1
E. When I have run out of cigarettes I feel it almost unbearable until I can get them.	5	4	3	2	1
F. I smoke cigarettes automatically without even being aware of it.	5	4	3	2	1
G. I smoke cigarettes to stimulate me, to perk me up.	5	4	3	2	1
H. Part of the enjoyment of smoking a cigarette comes from the steps I take to light up.	5	4	3	2	1
I. I find cigarettes pleasurable.	5	4	3	2	1
J. When I feel uncomfortable or upset about something, I light up a cigarette.	5	4	3	2	1
K. I am very much aware of the fact when I am not smoking a cigarette.	5	4	3	2	1
L. I light up a cigarette without realising I still have one burning in an ashtray.	5	4	3	2	1
M. I smoke cigarettes to give me a lift.	5	4	3	2	1
N. When I smoke a cigarette, part of the enjoyment is watching the smoke as I exhale it.	5	4	3	2	1
O. I want a cigarette most when I am comfortable and relaxed.	5	4	3	2	1
P. When I feel depressed or want to take my mind off cares and worries I smoke cigarettes.	5	4	3	2	1
Q. I get a gnawing hunger for a cigarette when I haven't smoked for a while.	5	4	3	2	1
R. I've found a cigarette in my mouth and didn't remember putting it there.	5	4	3	2	1

(answers on page 12)

Scottish anti-smoking campaign

EDINBURGH—A major campaign based on a booklet which asks the question "What Kind of Smoker Are You?", is being launched early in 1975 in Scotland by the Scottish Health Education Unit.

The booklet is based on data first devised by Dr. Daniel Horn of the National Clearing House for Smoking and Health in America.

The government-backed Scottish Unit decided to update the information and produce its own booklet. If the campaign, which will be aimed at both young people and adults, proves successful, it is expected that the booklet will be distributed over the whole country.

The booklet asks a number of questions to try and help people to determine why they smoke and what sort of smoker they are.

If they smoke mainly for pleasure, tension reduction, craving, stimulation, and handling, suggestions are made in the brochure as to how to overcome these desires.

The booklet campaign will follow on a major poster campaign which has already proved effective in trying to stop young people from beginning to smoke.

The Scottish Health Education Unit is at 21 Lansdowne Crescent, Edinburgh EH12 5EH, Scotland.

Mexico leads Latin American attack on drugs

MEXICO IS emerging as the leader of Latin American efforts to study and cope with the problems of drug abuse.

It is the first of the Latin American countries to have developed social and biomedical research models tailored to the particular needs of the region—which differ markedly from those of consumer countries.

Within the next two years it will open some 38 drug treatment centres, one of which will be the first facility specifically designed for heroin addicts.

And, last year, it was host to the first major meeting of the United Nations Social Defence Research Institute which seeks to spur national drug abuse control efforts by sponsoring regional meetings.

The Latin American Seminar on National Research Programs in Drug Abuse was organized in collaboration with the Centro Mexicano de Estudios de Farmacodependencia (CEMEF).

It was at CEMEF that the models were developed, under the direction of Dr. Guido Bellsasso.

"They have been applied by us for one year now. Our purpose is not to draw statistically significant conclusions yet but merely to test operationsl efficacy of the proposed instruments.

"We have already learned, however, it is feasible to apply techniques for evaluating the incidence of drug abuse at the national level in a country like Mexico with its very special social, economic, and cultural characteristics."

At the seminar, Dr. Pieder Konz, UNSDRI director, said drug abuse control can no longer be dealt with effectively through "international measures established by jurists and diplomats meeting over green-covered tables". He urged new initiatives must be taken.

Dr. Konz stressed the cultural specificity of drug abuse, its control, and the social repercussions in each local context to demonstrate that research in the field is essential for all countries concerned with the problem, currently or in the future, and should not be entrusted exclusively to foreign experts, technically advanced as they may be.

"Although the authorities and international experts are frequently unaware of the fact," he remarked, "the strategies of prevention and control must be as diverse as the causes and epidemiological models of the drug abuse phenomenon.

"Obviously, measures taken to avoid spreading drug abuse habits through foreign tourists or the treatment of the few adolescents who imitate them must naturally be very different from those taken for the prevention and treatment of drug abuse in the poor districts of New York or Bangkok, in prisons, or among marginal or alienated sectors of the population."

Statements by various representatives outlining the status of the drug problem in their respective countries served to bear out the validity of Dr. Konz's observations and to justify the seminar and its orientation.

Panama is a way station to the Americas and to a good part of the rest of the world, and drug traffic is the main concern.

Argentina: Drug abuse is estimated to have risen 500% since 1969 in the main urban centres, such as Buenos Aires, Mendoza, Cordoba, and Rosario.

Colombia: When work in this field was initiated in the 70s, it was realized the country was facing a veritable pandemic but no studies were available to guide action by the authorities. Since then, a series of seminars has been organized and national agencies formed to study the Colombian problem from the social, scientific, and educational standpoints.

Costa Rica: Bordering on Panama, it shares the problem of being a trafficking rather than a consuming nation.

Mexico: Mexico's main problem for many years has been the enormous drug traffic to the rich U.S. market. An increasing amount of the country's scanty resources has gone into combating it with as many as 12,000 men devoted to seeking out and destroying marijuana and poppy plantations and pursuing legions of drug smugglers of all kinds.

The abuse problem is not thought to be severe in Mexico.

Peru: Coca addiction among Indian groups represents a major problem in addition to another special method of drug abuse—the smoking of tobacco laced with cocaine, called by the Ecuadorian expression *"maduro con queso"* (banana and cheese). The fact Peru has borders with four countries — Ecuador, Colombia, Bolivia, and Chile—makes control of drug smuggling a very difficult task.

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Cannabis merry-go-round

As has been suspected by many for some time, revision of Canada's cannabis laws ranks as a low priority with the Trudeau government.

Both the substance of the recent legislative proposals and their means of introduction—via a Senate bill—offer ample indication of Cabinet's apathy on this issue. (See page 1).

As Health Minister Marc Lalonde noted, a heavy workload precluded the bill's being introduced in Commons. A "heavy workload" is interpreted as the aborted attempt to ram through a 50% pay raise for Members of Parliament.

Now that the bill has been shuffled off to the Senate, and from there to a subcommittee to start a whole new set of hearings on its own, one wonders whatever happened to all the information, insight, and direction provided by the LeDain Commission?

It appears the same people and groups called to testify to the LeDain Commission will have to repeat the act for the Senate.

It is as if the LeDain Commission never existed and that painful fact is made more evident in the poorly-conceived compromise that now serves as this government's response to existing drug laws.

Shifting jurisdiction for cannabis from the Narcotic Control to the Food and Drugs Act, and slicing penalties for simple possession, merely points to an objective. It doesn't bring us there.

In recommending elimination of penalties for simple possession of cannabis, the LeDain commission was talking about more than bringing the costs of fines within the financial means of casual users.

It was talking about something much more fundamental to our approach to justice—namely that the lifelong stigma of criminal sentences was a punishment out of all proportion in respect to personal use of cannabis, and that imposition of this stigma exerted more social damage than the "crime" it was meant to deter.

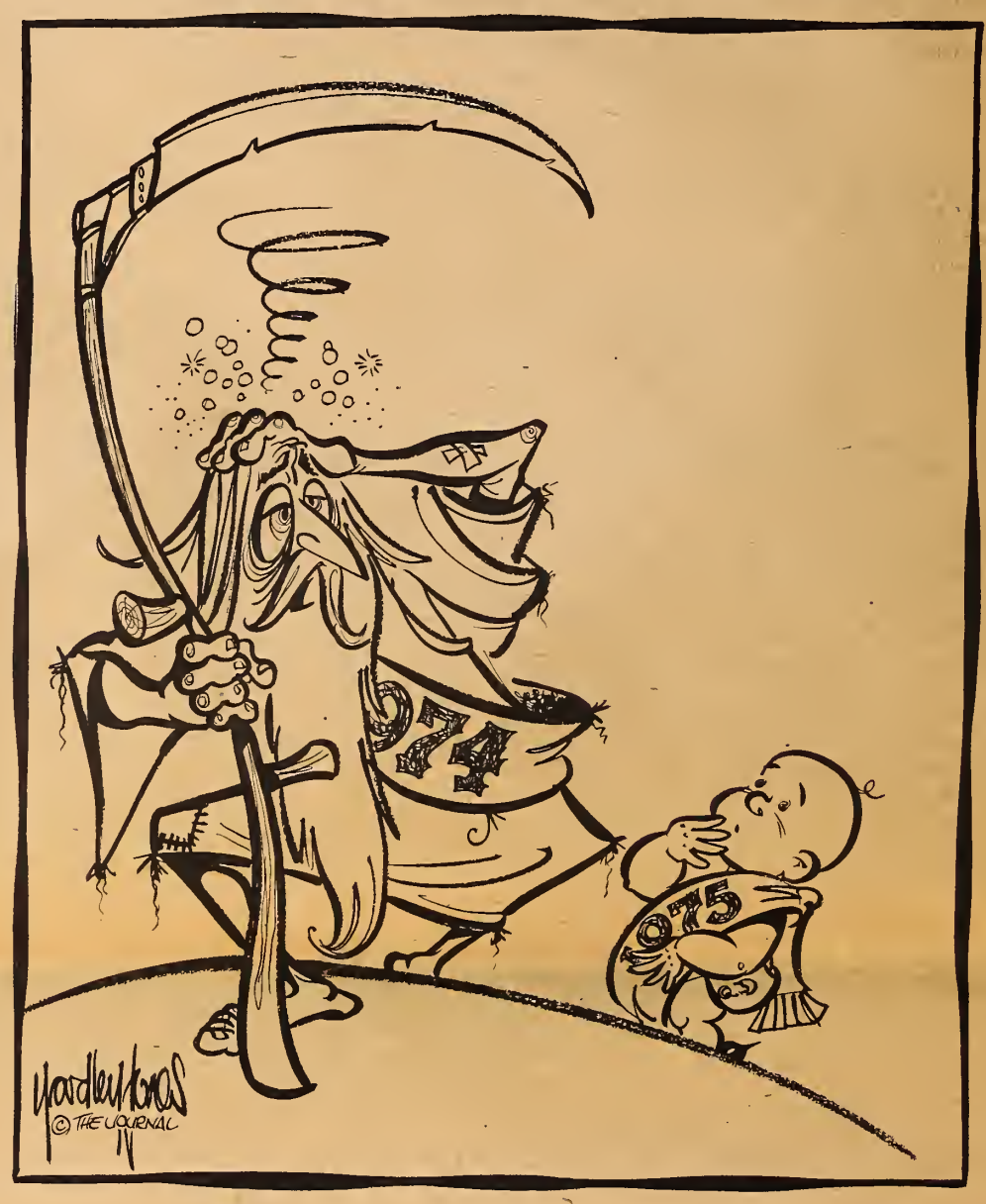
But summary conviction, under the Food and Drugs Act, just as under the Narcotic Control Act, still leaves the residue of a criminal record. When such a record is produced, even 10 years hence, there is usually no way of telling whether that conviction was for a summary or an indictable offence. A record is a record.

Under the present proposal there is no guarantee the weight of the law will be applied evenly from province to province, or even from community to community. Nor is there a guarantee that today's convicted casual user fined $100, will, 10 years from now, not have to pay an additional, and far more serious penalty, because of information he files on a job application form or a travel document.

There is no mechanism which guarantees that after a time, a record will be expunged, and, except for cases of simple possession, there is no guarantee the crown won't choose to proceed by indictment and the full force of the law, whatever the circumstances.

If there is any elasticity built into the existing proposals, it would all seem to be on the side of law enforcement officials—precious little for the accused.

—Milan Korcok—



"Booze? Drugs? Hell, no–"INFLATION"

It's called P.R.

So, the liquor companies want us to drink moderately do they?

That's what they have been saying in their "tasteful", "commonsense" advertisements all through this holiday season.

Well, if a common sense approach to drinking is the only payoff they want and expect, why append the names of their corporations to each ad?

Why don't they just state their case? Or wouldn't that be productive public relations?

Letters to the Editor

Sir:

We were pleased to see the article by Anne MacLennan on our survey (**The Journal**, December 1) and especially delighted with her observations in the lead paragraphs.

We read **The Journal** with great interest around here and find it very useful. Our thanks again for reporting our survey so thoroughly.

Ms. Hester J. Dawson
Media Coordinator
Morris County Department of Drug Abuse
Morris Plains, New Jersey

What an absolutely beastly fracas at Upstan Downs, old boy!

By WAYNE HOWELL

LONDON—On the basis of confidential memoranda leaked this morning from the Ministry of Health, two very serious charges have been levelled at British officialdom:

1. That the Ministry of Health has covertly juggled British narcotics statistics so as to continuously titillate North American drug experts.

2. That the British government has for decades concealed the fact that revenues generated from visiting delegations of North American drug experts studying the so called 'British experiment' far exceed the entire cost of the British free heroin program.

Reached at his country home at Upstan Downs soon after the allegations surfaced in the morning papers, Deputy Assistant Health Minister W. R. Twillingham refused to answer questions because of 'national security considerations'.

The response fueled speculation that revenues from North American drug-trippers are considered essential to Britain's continuing struggle to balance her payments and stave off bankruptcy, and added credence to the numerous rumours that if North America were to stop sending groups and individuals to study the 'British experiment', more than one West End hotel here might go into receivership.

Contacted at noon at his club, Deputy Minister of Health Sir Adrian Pluckenpenny M.B.C.M. angrily denied the ministry had manipulated statistics so as to encourage North American drug-trippers although he did admit under persistent questioning that Her Majesty's government held expense-accounting drug-trippers in higher regard than Arthur Frommer's penny-pinching legions.

In the late afternoon, the Minister of Health Sir Hugh Bartelberry O.B.E. consented to an interview with the B.B.C.'s Throcton Downs. A transcript of the interview follows:

T.D.: Sir Hugh, do you have a statement to make about the very serious allegations that have been levelled at your Ministry?

Sir H: It is ridiculous to accuse us of malfeasance just because the behavior of North Americans seems incomprehensible. We have been dispensing heroin to British addicts since 1926 and we continue to do so because for us it is efficacious. It is as simple as that Mr. Downs.

T.D.: But surely it is a most curious thing, Sir Hugh, that 48 years later the North Americans are still sending over delegations to study, analyse, report, and make recommendations about the 'British experiment'.

A sceptical press cannot see why they would carry on like that for 48 years—almost half a century Sir Hugh!—unless there were some covert effort to confuse them, motivated by a desire to keep them coming, to keep their hard currency rolling in.

Sir H: I know. I know . . . it is rather strange. I've often wondered why they keep coming. I've often wondered why lemmings rush to the sea too. Mr. Downs. But ours is not to reason why, ours is to encourage them to fly British Airways, visit our clinics, stay at our better hotels, talk to our experts, and take them down to Piccadilly Circus at midnight so they can have a balanced view. There has been no conscious effort on our part to confuse them.

T.D.: With all due respect Sir Hugh, you are asking us to believe a society that was able to put a man on the moon in 20 years is incapable of coming to a consensus about something as simple as the British drug program in 50 years!

Sir H: Yes Mr. Downs, that is what I am asking you to believe.

T.D.: Come, come, Sir Hugh; in this post-Watergate era the public is no longer so credulous.

(Wayne Howell is an Ottawa physician and freelance writer.)

Haight-Ashbury: Harnessing the essence of neighborhood

By MILAN KORCOK

SAN FRANCISCO—The cab driver in Union Square does a double take given the address in Haight-Ashbury.

"Did you say Haight?"

"Right. Something wrong with that?"

"No, I guess not. Only I don't usually get people from HERE, goin' over THERE."

When you recall the decay, disease, and violence of Haight-Ashbury only three years ago, hesitancy about penetrating too deeply into this mysterious enclave is understandable.

Sure, there was a time in the 1960s when the Haight—love, peace, and flowers—was a tourist attraction. Potheads and acid trippers were fun to look at, you didn't have them at home.

But the flowers wilted and the love wore thin. By 1970 only the toughest could survive. The hustling was hard, the street was unrelenting. "Nice" people no longer went there. And if they had gone, they would have seen little but decay, peeling paint, garbage, and hollow stores.

"Are things gettin' any better over there? They still jumpin' outta windows?"

"If they are they're not screaming on the way down. It seems quieter."

But the cab driver doesn't believe you. Its hard to live down the image.

To many San Franciscans, the only way to change the image is to get the bulldozers in. But to people in Haight-Ashbury, and there are people who live and work there, there is more muscle in neighborhood self-determination than in any number of bulldozers. And they are starting to flex that muscle.

They are talking of "renaissance", "solidarity", "political consciousness." At the same time they are slapping on fresh paint, dressing up store fronts, cleaning up the streets.

It doesn't look like Disneyworld yet. Don't count on too much rubber gingerbread. But the Haight is changing and the institutions within it realize they had better be prepared to go along.

Dr. David E. Smith, founder and medical director of the Haight-Ashbury Free Medical Clinic—which has served as prototype for the energetic free clinic movement throughout the country—is highly sensitive to the change and is pushing as hard as anyone to see it realized.

Unlike merchants in the Haight, Smith doesn't need more business. The HAFMC complex, which sees between 200 and 300 people a day in its various units, has as much as it can handle right now. But it is the essence of "neighborhood" Smith and his colleagues would dearly love to harness in rounding out the treatment potential for their addict clients.

The best drug treatment programs are expected to draw on resources within the community. They are expected to include crisis intervention, medical and detoxification facilities, and psychosocial services to help patients to adjust better to living without drugs.

But where programs most often fall down is in the effective repatriation of the addict to a lifestyle in which he can support himself economically without resorting to crime, or drug hustling.

Once detoxified, treated, and readied for entry, the addict is too often faced either with the stark fact that he doesn't have the skills society wants, or with an employer, convinced "once a junkie always a junkie" and not about to take a chance on him.

It comes as a stunning letdown not only to the addict but to the teams of people who have worked to get him ready for re-entry only to find he is all dressed up with no place to go.

When the HAFMC began operations in the summer of 1967, the emphasis was on responding to the drug crises of transients and alienated youths attracted by the Haight mystique.

Emergency treatment of adverse reactions to psychedelics was the first priority. The cycles then shifted through amphetamines and "downers". Then, beyond

David Smith

the medical services, it was necessary to extend into psychological counselling and some forms of aftercare.

Today the HAFMC medical section provides physical examinations, prescriptions and treatment, V.D. and pregnancy testing, blood tests and blood typing; the psychological services section provides counselling, in crisis situations, and ongoing therapy.

There is a women's needs centre which involves birth control education, pregnancy testing, prenatal care, adoption referrals, abortion counselling; there is a dental section; detoxification, rehabilitation and aftercare (non-narcotic medication for withdrawal); and a social rehabilitation program dealing with vocational training, welfare counselling and job placement. There is also a commune health section which provides health and referral service for commune residents.

This battery of services should be adequate for almost any drug-related situation. But it isn't, not fully. The Haight experience shows that a given treatment facility can go only so far in getting the addict into shape so he can function productively on his own. After that point, the community must take over.

The fact is most of the clients going into such programs don't need RE-habilitation, they have nothing to be rehabilitated to. They are too young to have learned any trades and skills in the first place. The only "job" skills they ever learned involved stealing, prostitution, selling stolen goods, con games and the like.

Usually these people lack patience and perseverance. They think more in terms of fending off crises than of long term goals. Their job prospects are poor, even allowing for the negative attitudes of most employers.

Consequently, job placement becomes a crucial component of the rehabilitation cycle. At the Haight clinic this has meant establishment of a drop-in centre to aid placement in jobs or in projects that prepare clients for taking work; and an exciting vocational apprenticeship program in which clients learn basic working skills in a sheltered setting.

Two segments of this apprenticeship program are attracting a lot of local attention—a silk screening project, and a rag paper plant. Both of these not only provide the ex-addict with basic working skills, they also yield highly saleable products.

Already, the silk screening industry in San Francisco is diverting commercial printing work to the workshop, primarily on a subcontracting basis.

The rag paper plant is an exciting project that might in time make a bit of money. Rag paper (the basic resource is old rags—donated by various community groups) is a distinctive, high quality, specialty paper used for invitations and prestige stationery. It is in high demand by engravers, artists and printers.

The plant, which actively solicits downtown business, has the capability of training up to a dozen people at a time in a regimen that demands cultivation of skills and discipline, and offers a good degree of self-fulfillment. The worker sees what he has done and it is a quality product.

The development of this kind of alternative industry is most important in that it provides a bridge for an addict. It's not that the Haight will be turning out rag paper specialists by the score. But, in the process of learning how to work, the clients are also learning what it means to meet the expectations of others, to be on time for work, to be made "work-ready".

Clients are not encouraged to stay more than six months in the sheltered workshops as there is the risk they will become dependent on them, in which case the sheltering becomes self-defeating.

Admittedly, there is an artificiality in this kind of microeconomy: The client is getting supports he couldn't expect on the outside. After all, how many rag paper specialists can the economy of San Francisco support?

But it is clear that the community ultimately will have to provide the opportunity. The community will have to become conditioned to look upon itself and all its resources as the complete therapist. Thus, the community has to change.

In facilitating this change, the free medical clinic as an institution—be it west coast, east coast, or midwest—can be a potent catalyst.

The free medical clinic, unlike some orthodox health institutions, couldn't last very long disregarding the needs of its neighbours, especially when the neighbors—businessmen, local health and social welfare administrators, politicians, landlords and tenants—are also active on the clinic board of directors, as they are in the Haight.

In the seven years since the Haight clinic opened its doors, close to 400 free clinics have opened across the United States. They respond to more than 2 million client-visits per year, treating a wide variety of health problems.

Primarily, the people who go to the free clinics are those to whom the orthodox institutions are alien.

Many of these communities are complex, they include white panthers, black militants, brown berets, junkies, hippies, property owners, merchants. The clinics must reflect the needs of all these groups. In reflecting such needs they become focal points for community action.

When San Francisco police launched a raid on one militant group in the Haight, a raid that allegedly had strong overtones of police set-up and persecution, the community arose as one in protest. Among those lined up with the community against unwarranted intrusion was the clinic.

"We were, and are, of this community. On that occasion we identified ourselves with the community groups and our relationships have been very good since then," says David Smith.

This kind of identification with the community it serves has given the Haight clinic an excellent track record in terms of surviving and fulfilling its mandate in a very complex setting.

Because of this track record, the HAFMC has gained worldwide respect. As a consequence, that Haight itself has benefited, as, for example, when Newsweek magazine offered the clinic a free public service advertisement page to promote its services.

The HAFMC capitalized on this for the whole community, devising an ad page which spoke of the Haight area renaissance and of the clinic's part in that renaissance. It struck an upbeat tone for the whole community.

In an ad titled "Where have all the flowers gone?" some powerful messages were put through:

"The Haight-Ashbury free medical clinics have hung in (through all the rebuilding) helping to bring about the renaissance in the Haight. Because love still needs care."

And another segment: "The Haight is realizing its renaissance. But there's so much more to be done."

It's the kind of promotion the Haight merchants just couldn't buy. For one thing they couldn't afford it, and if they said it themselves it would just be seen as plain huckstering.

When George Harrison and Ravi Shankar gave a benefit performance at San Francisco's Cow Palace in November to raise funds for the medical section of HAFMC—the whole community benefited just by association.

It's the kind of association and deep involvement in community activities that David Smith and Rick Seymour, Central Administrator of Youth Projects, Inc., see as transportable to so many drug programs and clinics across the country.

(Youth Projects, Inc. of which Smith is president, is administrative, legal, and fiscal agent for the HAFMC, and the National Free Clinic Council.)

Says Seymour: "Each neighborhood has its own evolving groups and coalitions that coalesce about specific issues. The cities have become so megalopolized that unless you have political clout within your neighborhood, City Hall becomes virtually inaccessible to you."

Says Smith: "I believe this reflects the lack of trust with the political system. A new politics is developing around neighborhood self-determination. This is a political issue, it concerns the future of America, and its happening in other places, not just Haight-Ashbury."

Educators 'should be losing more sleep' over what doctors have NOT been trained to do

By ALAN MASSAM

LONDON—A professor of psychiatry has claimed that the mid-20th Century will become known as "the era of tranquillity" because of the Western world's high consumption of tranquillizing drugs.

Professor William Trethowan, professor of psychiatry at the University of Birmingham, told the conference of the World Psychiatric Association here that drug-taking had reached epidemic proportions in the 1970s—"not only illicit drug-taking among young people, but drug-taking by those of all ages, and on prescription given for the most part by doctors, in seemingly good faith."

Giving the available statistics of "what has been called the relentless progress of the psychotropic drug juggernaut", Professor Trethowan said that in 1972, 27.2% of the drugs prescribed in England acted on the central nervous system. Of this 27.2%, 17.7% fell into the category of psychotropic drugs, and 9.5% represented the non-psychotropic drugs acting on the CNS.

The 'psychtropic' group—defined as drugs likely to be prescribed for patients suffering from some kind of psychiatric disorder—represented the largest single group when considered separately.

In terms of cost, the drugs acting upon the CNS added up to more than any other group of drugs while the psychotropic sub-group fell into third place, being surpassed in cost by drugs acting on the cardiovascular system including diuretics.

The cost of anti-infective drugs, which includes antibiotics, was only marginally less than the cost of the psychotropic group.

The psychotropic group exceeded, in terms of cost, all other drugs acting on the CNS, not just because there was a larger number of prescriptions, but because the average cost of psychotropic drugs was higher per prescription than that of other CNS-acting drugs.

What were the psychotropic drugs being prescribed for?

"In view of the fact that barbiturate and non-barbiturate hypnotics account for just under 40% of the psychotropic drug sub-group, insomnia would appear to be the main reason," Professor Trethowan said.

According to Dr. Karen Dunnell, a further 30% of psychotropic drug users took them for "very vaguely defined reasons such as 'neurosis, depression and to calm me down'."

This, in itself, the professor claimed, suggested these drugs were being prescribed for insufficient reason or in an ineffectual manner.

Apart from fairly specific and recognizable types of psychiatric disorders, there was some evidence psychotropic drugs were increasingly prescribed "in order to try and modify personal and interpersonal processes.

"One of the several dangers inherent in this is the promotion of what may be regarded as a positive feedback mechanism," the professor said.

"By this is meant that, the more the habit of prescribing medications for personal problems grows among doctors, the more likely it is that their patients may come increasingly to demand this kind of solution to their difficulties, a solution which, I humbly submit, is likely in the end to turn out to be a non-solution.

"I am not only taking general practitioners to task. As I have already hinted, are psychiatrists so blameless?

"Could it be that they have only too clearly demarcated the steps in which the general practitioner, like Good King Wenceslas's page, should tread? Worse still, although general practitioners are possibly more vulnerable to the skilful propaganda put out by the drug companies, can psychiatrists claim they are, by and large, more discerning?"

Professor Trethowan said many reasons for overprescribing of psychotropics could be given, but most were probably rationalizations . . . "too many patients, not enough time, something must be done and at least a little chlordiazepoxide won't do any harm. And so on.

"A much better explanation may be that doctors are ever more being expected to do for their patients what they have not been trained to do.

"This has implications for medical education about which medical teachers ought to be losing more sleep than some of them are currently doing."

Even when the physician really did know of a better prescription than a tranquillizing drug, who would dispense it for him? Who would dispense human warmth and friendship—as Marshall Marrinker had asked—to an embittered old spinster who muttered around the bedroom in the early hours of the morning looking at the photograph of her long-dead parents?

Who would provide a home for the feckless young couple and their two crying toddlers before their life in one room strained their relationship past mending?

The overprescribing of psychotropic drugs did surprisingly little physical harm, but it undoubtedly did do harm to the quality of medical practice.

Crime and drug use

Offenders 'very different' from misusers

By LYNN PAYER

STRASBOURG, FRANCE—The association between crime and drug misuse appears to reflect more the social characteristics of the misusers than the effects of intoxication, says a senior research officer of Britain's Home Office Research Unit.

Joy Mott was speaking here to the 11th Conference of Directors of Criminological Research Institutes.

"The characteristics of drug offenders have been found to be very like those of the general population of offenders and very different from those of self-reported drug misusers," she said.

"Also, the social characteristics of offenders who become drugs misusers and who continue to misuse drugs are more like those of offenders than those of self-reported misusers."

In an extensive review of the literature, including several of her own studies on opiate misusers and crime in the United Kingdom, Miss Mott concluded that while there is some association between drug misuse and crime, there are several different types of relationship, depending on the nature of the national drug control legislation, on the type of drug misused, and on the individual characteristics of misusers.

Discussing various drugs specifically, Miss Mott said that "apart from the possible effects of cannabis intoxication on driving behavior, there is little evidence in international research to suggest that, for the great majority of cannabis misusers, their misuse has any direct or indirect criminogenic effects as far as non-drug offences are concerned.

"It is possible the situation will change if more potent preparations become available and/or the typical dosage levels increase," she said.

The majority of the intravenous misusers of amphetamine type drugs in Sweden and of the misusers of opiates, mainly heroin, in the United Kingdom, had been arrested, if not convicted, of both drug and non-drug offences at some time during their drug-using histories, Miss Mott said.

In the case of amphetamines, there is evidence that acute or chronic intoxication can result in aggressive behavior, and there are reports of theft offences being committed out of bravado rather than for gain, she said.

While opiate misusers may steal to obtain money to support the habit, several studies indicate that, in the United Kingdom at least, about one third of male drug misusers with criminal histories had already been convicted of offences prior to any admitted drug misuse.

She also cited a recent study done with Marilyn Taylor, and issued as a Home Office Research Study.

In this study, Misses Mott and Taylor examined the types of offences for which a series of United Kingdom opiate addicts were convicted during the four stages of their drug misusing histories—no drug abuse, non-opiate misuse, early opiate misuse, and the two years following their formal identification as opium addicts.

They found that in the period prior to any admitted drug misuse, 69% of all offences were for theft, compared with 31% in the two year period after formal identification as addicts.

"There is no doubt that drug use, particularly opiate use, modified their criminal histories to the extent that their criminal convictions increasingly became limited to drug offences."

They also found:

- There was no evidence of an increase in the small proportion of convictions of males for offences involving violence against the person during any of the drug using stages.
- When age and number of previous convictions were taken into account, there were no consistent differences between the observed reconviction rates for the addicts and the expected rates, although there was evidence to suggest that a cessation or reduction of misuse was associated with a reduction in convictions.

There is little evidence, whatever personality measures are used, to suggest that drug misusers possess a unique constellation of personality characteristics which distinguish them either from offenders or the general population, Miss Mott pointed out.

"The only psychological variable which has been consistently shown to discriminate drug misusers from both the offender and the general population is intelligence. Drug misusers, whether or not they are also offenders, tend to score above average on standard tests of intelligence," she said.

"The search for a unique psychopathology of drug misuse has been notably unsuccessful."

'Homework' for alcoholics

By JEAN McCANN

CHAPEL HILL, N.C.—A soothing record which teaches progressive muscle relaxation techniques is helping some alcoholics here to quit drinking.

Listening to the record is part of the "homework" assigned by Dr. John A. Ewing to tense, anxious alcoholic patients.

Dr. Ewing is professor of psychiatry and director of the Center for Alcohol Studies at the University of North Carolina. He directs programs involving several kinds of therapies, including this "relaxation therapy".

"Because alcoholics are very tense and anxious people, muscle relaxation can help", Dr. Ewing told **The Journal.**

"Muscle tension and anxiety are not compatible with muscle relaxation, so alcoholics who can learn the techniques of deep muscular relaxation have less need to turn to chemicals for relief from the pressures of daily living.

"Muscle relaxation also helps with the phobias many alcoholics have. The alcoholic who drinks a lot because he has to fly all the time, and he has a fear of flying, is one such person who might be helped."

Dr. Ewing said he decided on using the record for "homework", because it reinforces what the professional counsellor can teach during office visits, and hastens the rate of learning of the techniques.

"It's also good, because this allows me to give something to the patient that he can take home."

Dr. Ewing said the record he has been using has a woman's voice discussing techniques of muscle relaxation.

"This record has been especially helpful with male patients, who seem to perceive the speaker as a kind of Earth Mother", Dr. Ewing said.

"However, some of the women patients have not liked it, I think because these women reject their mothers. It probably would be helpful for them to have a record with a male voice."

While using a recording to achieve relaxation is one technique, it is not the only one. Yoga classes and transcendental meditation are other possibilities, he said.

Dr. Ewing told **The Journal** the "relaxation therapy" is only one part of a many-pronged approach here to the alcoholic patient.

By JEAN McCANN

WASHINGTON — Alcoholism in outer space?

Not just yet. But it seems the first settlers of natural or artificial planets out there will not have to look far for the primary ingredient.

Three different scientific groups have now discovered alcohol in—of all places—The Milky Way.

"Actually, it's ethanol, popularly known as grain alcohol, that was discovered", a spokesman for the National Bureau of Standards told The Journal. "This is the first discovery of alcohol in outer space.

"The discovery was made on Sagittarius B2, a dust gas cloud near the center of the Milky Way", Arthur Schach explained.

"Scientists have been working for 10 years to try to discover what molecules are there, and this is the thirty-first molecule detected. We didn't expect to find it.

"Our interest in studying these molecules is in the possibility of reproducing some molecular structures from space which are not stable here on earth."

So far, however, Schach says he is not worried about drunken spacemen. "After all, Sagittarius B2 is 30,000 light years away . . ."

The discovery of ethanol in the interstellar cloud will be reported in the Astrophysical Journal by scientists from the three research groups.

National effort may follow

Campaign zeroes in on UK community

By ASHLEY McCONNELL

NEWCASTLE, ENGLAND—A $235,000 campaign aimed at alcoholism and heavy imbibing in general, and teenage drinking in particular, has been launched in this northeast corner of Britain.

If the five-week saturation campaign by the government-backed Health Education Council is a success, a national campaign will be conducted some time later this year.

For the first time in this country, anti-alcohol television commercials will be screened. Newspapers and posters, and teachers and physicians, among others, are being used to ram home the message in the area, which has a population of about 2,600,000.

The first television commercial to be shown shows a father drinking with his friends in a pub. His young son knocks at the pub door and asks a customer to fetch his father.

He tells his father: "Mum wants you home for dinner." But the father returns for another drink as the boy waits outside. The punch-line is: "When you drink too much, it's your family that pays for the last round."

Another commercial shows a boy and girl giving their opinions on drinking and the third shows the ultimate outcome of excess drinking—a man drowning in alcohol.

Teenagers come in for special attention as studies show a growing number of young people often use the school lunch break to drink to excess.

The campaign, backed by a number of voluntary bodies including the National Council on Alcoholism, was opened at a one-day conference of educators, physicians and others in a position to influence various groups.

A spokesman for the Health Education Council said: "The campaign will be directed at the whole community and will include teenagers.

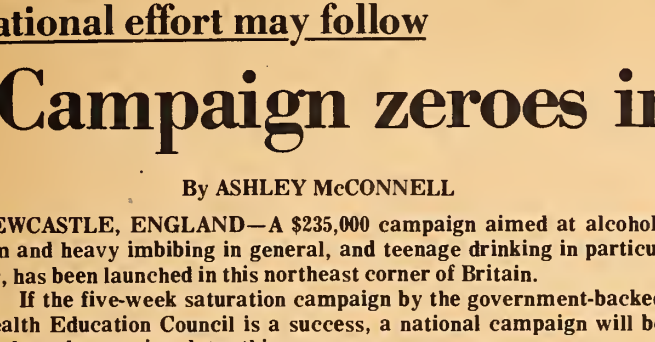
"We are not in any way condemning reasonable social drinking, but are trying to prevent people becoming hardened drinkers and eventual alcoholics."

According to the latest Home Office statistics, in the last year the number of drunkenness offences among boys aged 14-17 soared by 32% from 3,311 to 4,382. It is estimated that some 400,000 people may be alcoholics and three to four million others indirectly affected by alcoholism.

Wine drinking rose by 25% and liquor drinking by 26% in 1973, the fastest rises ever. In the period 1970-73, consumption of liquor has gone up by 53%, wine by 70% and beer by 10%.

To those who questioned the need for the present campaign, Sir Bernard Brain, chairman of the Medical Council on Alcoholism, pointed out:

- Alcoholism is Britain's fourth major health hazard.
- The suicide rate among alcoholics is 80 times greater than in the general population.
- Sixty per cent of cruelty to children has a background of alcoholism.



- The Department of Education and Science claims the misuse of alcohol presents a far greater social problem than does the misuse of drugs.
- The number of convictions for drunkenness among young people in Britain has more than trebled in the past 10 years.
- Almost one third of all requests for help at Alcoholism Information Centres now come from persons under 35 years of age.

Another speaker at the conference, W. R. S. Forsyth, secretary of the North East Brewers' Association, said: "The encouragements to excessive drinking are rarely provided by the publican but rather consist in certain customs and traditions against which publicans exert a considerable influence—such as the pub-crawl or competitive drinking."

He said he believed quite sincerely "the interests of public health and the interests of the licensed trade do not in one whit diverge in advocating the wise and sensible use of alcoholic beverages."

The posters used in the campaign include one showing a battered child with the caption: "Eight pints of beer and four large whiskies a day aren't doing her any good."

Another shows six hypodermic syringes arranged as drink dispensers containing beer, brandy, vodka, rum, gin and whisky. Above is the warning: "Alcohol can become addictive."

Another poster reads: "Everybody likes a drink. Nobody likes a drunk."

Sex OR sobriety: Some alcoholics must choose

By CAROLYN HOLSTEIN

WASHINGTON—About 8% of male alcoholics who stop drinking become sexually impotent, according to Dr. James W. Smith, director, Schick's Shadel Hospital, Inc., Seattle, Washington.

Of this 8%, about one-half will regain full normal sexual function; one-fourth will regain partial function; and the other fourth will remain impotent, Dr. Smith told participants in a Sexuality and Addiction symposium.

The symposium, held at the Washington DC Veterans Administration Hospital was co-sponsored by the VA and the Washington Area Council on Alcoholism and Drug Abuse, Inc.

Dr. Smith based his figures on 17,000 patients treated at the Seattle hospital during the past 35 years.

He said he believes impotence may result from damage to cells in the brain's hypothalamus, a structure which regulates hormones involved in sexual response.

"Initially, alcohol stimulates hypothalamic cells. Only after long use are they depressed by alcohol. During this depressive phase," he continued, "the cells are first suppressed. Then, after prolonged suppression they are eventually destroyed."

Following this premise, he said the ability to regain sexual function depends on whether these hypothalamic cells are suppressed or destroyed. This depends, in turn, he said, on a number of factors including the amount of alcohol consumed and on individual variables such as the drinker's metabolism and nutrition.

Although there has been no scientific proof alcohol destroys hypothalamic cells, Dr. Smith feels there is evidence to support it.

He cited his study of alcoholic patients who took a "detailed functional task test. The test was developed by scientists at Washington University to determine evidence of brain lesions and it has been found to be accurate in 96% of the patients tested there," said Dr. Smith.

"Although none of the patients we tested showed any outward signs of obvious organic brain damage, about one-third of the patients tested out in the brain damaged range.

"The older a person is, and the more he drinks, the less chance he has for recovery of sexual function," Dr. Smith said. He added that if sexual function has not been regained within one year after sobriety, the chances for recovery are "greatly diminished".

In patients whose hypothalamic cells have not been totally destroyed, Dr. Smith said the Masters and Johnson type of sex therapy may be helpful.

This type of therapy is being provided to former alcoholics by Dr. Harvey Resnick and his wife, Audrey, co-directors of the Center for Studies of Sexual Behaviors, in Maryland.

Dr. Resnick told symposium participants: "It is too early to tell whether the therapy is beneficial to former alcoholics."

He said former alcoholics, who comprise about 15% of his patients, are required to be completely off alcohol for six months before being treated at the Center.

According to Dr. Smith, if a former alcoholic resumes drinking, he may regain sexual function. "But most wives of alcoholics will choose sobriety to sex," he said.

Doctors urged to shed their biases

By MARY HAGER

LOS ANGELES, CAL.—Physicians must recognize alcoholism as a serious disease and a major health problem and diagnose it before patients become physically impaired.

They must also overcome their own biases to the disease and make themselves familiar with available treatment resources.

These observations were made at the annual meeting here of the American Academy of Family Physicians by Dr. W. M. Lukash, Rear Adm., M.C., USN, of the Naval Medical Center in Bethesda, Md.

Physicians often delay a diagnosis of alcoholism because drinking is not only accepted as a social way of life but physicians themselves have the highest alcoholism rate of any profession, said Dr. Lukash.

The disease can be hard to diagnose because patients deny drinking problems and give false histories, and because alcoholism precedes actual physical problems. Alcoholism also carries the moral connotations of misconduct and weakness.

Dr. Lukash defined alcoholism as "the inability to control the amount of drinking and the development of impairments of interpersonal relationships, economic productivity or physical health". And he said it is a particularly serious problem in the military which has an alcoholism rate of 15%.

Twenty-three per cent of officers and 34% of enlisted men are known alcohol abusers, with an average in-service time of 11 years, he said.

On a larger scale, of the 10 million alcoholics in the United States, 50% are gainfully employed, 30% are college graduates, 30% are manual laborers and one of six are women.

Thirty per cent are middle class, 20% inner city dwellers, 5% upper class executives and another 5% skid row drunks, he said.

Failures in coping with alcoholism are shown in the progressive destruction of the life style of alcoholics, the 100,000 violent fatalities each year linked to alcohol, 25,000 patients with fatty liver disease, he said.

He added that 50% of homicides and auto accidents, 50% of felonies, 30% of suicides, 30% of psychiatric admissions and 20% of hospitalizations are alcohol-related.

He advised a team approach to treatment using all available resources, including Alcoholics Anonymous, family counselling and religious advisors.

That sinking feeling Down Under

SYDNEY, AUSTRALIA—Australians are drowning in a "sea of grog" and making very little effort to save themselves, a Melbourne psychiatrist claims.

"The average Australian downs the equivalent of 100 gallons of beer a year and is virtually certain to develop serious alcohol-related medical problems," according to Dr. George Milner, director of alcohol and drug dependencies services in Victoria.

In Canberra, George Howells, director-general of health, said nearly 10% of the average weekly spending is on alcohol and tobacco.

He also noted more is spent on alcohol and tobacco than on clothing. Between June, 1972, and June, 1973, Australians spent $3.31 billion on alcohol and tobacco compared with $3.16 billion on clothes.

In the same year, they drank 372 million gallons of beer and 130 million gallons of wine, he said.

"The average drinker is damned near the threshold of inevitable medical problems," said Dr. Milner.

Target: North America

New trafficking network in Europe

PARIS—The rapid establishment of profitable new drug trafficking networks across Western Europe, has been confirmed by Interpol, the Paris-based international police organization.

And tolerant Amsterdam is quickly establishing itself as the principal European transit station through which large quantities of heroin and cocaine are being channeled to Canada and the U.S. from Asia.

At the recent general assembly of Interpol, drug trafficking claimed the lion's share of attention. And specialists stressed they must intensify their fight against trafficking, both in Europe and Latin America, as a prerequisite to coming to grips with the problem in North America.

Every European country is to increase its annual contribution to Interpol's drug control operations by 20% while the U.S. is to make a special contribution of $130,000.

Europe and the U.S. will also finance the posting of a drug liaison officer in South East Asia to

By THOMAS LAND

work in co-operation with colleagues already in France and the Middle East. A similar system is being organized in Latin America to stop cocaine trafficking , which has increased recently, particularly in Colombia.

Interpol's plan to control drugs (Narcontrol), will be reinforced by another information network, the Narcotic Intelligence Agency, to gather and store instantly-available, relevant information at the organization's headquarters here.

Interpol observers say definite improvements are being made in the control of illicit drug flows, but they doubt whether these will have a lasting effect without intensified efforts.

A decline in international trafficking has been brought about by the recently-ended pause in Turkey's poppy cultivation, by improved co-operation between the authorities of France and the U.S. which led to the smashing of some major European drug rings, and by a program of co-operation adopted by the 17-nation Council of Europe for controlling the illicit use and sale of drugs.

New illicit connections, however, are already being established across Europe to cater to the lucrative North American market for narcotics, illustrated by an increase in arrests at the sea and air ports of Northern Europe.

Amsterdam, internationally known for its traditional tolerance to foreigners and eccentrics, is now the foremost centre of the trade. (London might well have attained that unwelcome distinction had it not been for recent British regulations severely increasing penalties for drug trafficking.)

Franco-American pressure on European smugglers has also increased the importance of Latin America in the illicit trade, providing both transit routes and local sources of supply.

A large proportion of the estimated eight tons of heroin consumed in the U.S. annually is supplied from hundreds of tiny airstrips in Paraguay and from more than 100 remote World War II landing strips in Panama.

In the past three years, Colombia has emerged as Latin America's principal cocaine exporter, drawing on raw materials from neighbouring Ecuador and Peru, converting coca paste into drugs at sophisticated laboratories and supplying the illicit North American market through the Caribbean islands and Central America.

Unlike the heroin traffic on that continent, which is directed by a tight, small group of Europeans, the current cocaine rush from Latin America hides a contest for domination involving something like 50 rival organizations.

The situation is volatile and violent. And the large number of contending groups ensures that even major arrests will fail to dry up supplies.

CNS stimulant abuse on increase in Japan

By LYNN PAYER

PARIS—The official number of central nervous system stimulant abusers in Japan increased 12-fold between 1969 and 1973, Dr. Fuminae Kubo, Managing Director, Japan Pharmaceutical Information Center, told the 1st World Congress of Environmental Medicine and Biology here.

In 1969, the number of such offenders was 704, whereas by 1973 it had risen to 8,510, he said.

In the same period, the number of narcotics addicts also rose, although less rapidly, from 1,029 in 1969 to 1,477 in 1973.

"Among the kinds of narcotics seized for criminal offence," Dr. Kubo said, "the amounts of heroin and LSD are remarkably increasing."

He added that drug abusers in Japan include "white-collar workers, housewives, and general citizens".

Dr. Kubo said a law concerning amphetamines and methamphetamines was passed in Japan in 1951, when abuse problems among veterans were becoming apparent.

Because of this, the two compounds have been less widely used for medical purposes than in countries such as the U.S.They may be used only at hospitals especially approved by the Ministry of Health and Welfare, but have not been used for weight loss as in other countries.

Although Dr. Kubo did not explain *why* the abuse of CNS stimulants has increased so dramatically, he did discuss general aspects of legal drug-taking in Japan.

"There is no denying that Japanese people have a tendency to lean upon drugs.

"Most Japanese, in spite of their healthy condition, make it a rule to take habitually a few tablets or capsules of some drugs after every meal. These tablets or capsules always contain one of the vitamin B-1 derivatives and some other vitamin preparations such as vitamin B-2, B-6, B-12, C, etc. Some also contain glucuronic acid, taurine, or others," he said.

The wide use of Vitamine B-1 stems from the fact that beri-beri was common in Japan 50 years ago, he explained.

Besides self-medication, Japanese expect medicines when they see a physician. If a cold sufferer is given no medication, the physician is considered unkind.

By contrast, "if a physician gives the same patient comparatively expensive antibiotics, vitamin preparations, antipyretics, analgesics, and other drugs for symptomatic therapy, he will be much thanked".

Compounding the problem, he said, is that while separate professions of physician and pharmacist exist, Japanese physicians traditionally both prescribe and dispense medicines. The remuneration of medical treatment under health insurance "aggravates the evil tendency of physicians to engage in dispensing to enlarge their income".

Payment for drugs occupies a comparatively greater proportion of the national budget for health than in other countries, Dr. Kubo said.

Thirty-six per cent goes directly for drugs, and if dispensing and injections fees are added to this, more than 50%.

By contrast, payment for medical services (also including dispensing and injections fees) accounts for only 41.6% of the total. Remuneration for hospital services, including meals, physicians' fees, and nursing, is less than for a 2nd or 3rd class hotel room, Dr. Kubo commented.

UK drunkenness up more than 10% — more offences among young women

LONDON—Further evidence of the spread of drinking among young women in England and Wales has been provided by the latest statistical review published by the Home Office.

This showed that there had been a more than 30% increase among girls between the ages of 18 and 20 convicted of drinking offences. The review covered the period Spring 1973 to Spring 1974. Convictions of boys between the ages of 14 and 17 also rose sharply, but not as fast as for those of the girls.

The overall increase of drunkenness was more than 10%—the highest annual rise for 12 years.

Only two of the 47 police areas in England and Wales did not register an increase in drinking offences—Birmingham and Lincolnshire. The biggest rise was recorded in the county of Lancashire. The figures exclude convictions for drunken driving.

This continued indication of the growth of alcohol consumption is sure to bring renewed pressure on the Government for some kind of restriction on the advertising of alcoholic beverages.

At a recent meeting of the Medical Council on Alcoholism, for example, Dr. Myrddin Evans of the University Hospital of Wales, Cardiff, said he would like to see a ban on advertisements linking alcohol with sexual potency.

Assessing the size of the problem, Dr. Evans said it was now estimated that there were 250,000 chronic alcoholics in England and Wales. If one counted the families and friends directly involved, this meant that more than a million people were suffering. Added to this could be a further million workers in the legal and medical professions and social services who were knowledgeable about the destructive nature of alcoholism.

Yet alcohol myths—like the association between sexual potency and drinking—still prevailed.

Dr. Evans said chronic alcoholism could and must be eradicated in Britain within the next two generations. Members of the medical profession should persuade "an alcohol-dependent nation" that it should "be rid of this public scourge".

So far there has been no response from the manufacturers of alcoholic beverages here despite the fact that makers of aperitifs and liqueurs in France are giving substantial support to research into the problems of alcoholism.

Hashish haul

By MACABEE DEAN

TEL AVIV—What is believed to be the largest single haul of hashish ever credited to the Israel police—1,281 "soles" (packages) weighing 345 kilograms—was discovered recently.

The hashish—from Lebanon and of "superior quality"—is valued on the local market at from IL 1.5 million to IL 3 million, (about $350,000-$700,000).

It is not known how much of the hashish was destined for the local Israeli market, and how much was to be sent on to areas occupied by Israel but inhabited by Arabs.

Another conjecture is it was brought to Israel from Lebanon through Jordan (Israel has an open bridges policy with Jordan and tons of goods flow daily across the Jordan river), and destined for the Gaza Strip from where Arab fishermen would smuggle it into Egypt.

Around the world

INFANTS AT RISK

A group of London medical scientists warn that infants whose parents both smoke have twice the chance of getting pneumonia or bronchitis in the first year of life. The group from St. Thomas's Hospital and London School of Hygiene and Tropical Medicine claim the increase was about 50% when only one parent smoked, and that the study confirmed suspicions that children with parents who smoke run greater health risks than children of non-smokers.

DRUGS ON INCREASE

Venezuelan authorities are trying to close down the drug flow which brings 200 pounds of marijuana and 10 kilos of cocaine from Colombia to Caracas bi-monthly. Officials say that, in terms of growth, the problem in Venezuela is more serious that that in the U.S. Border control between Venezuela and Colombia is nearly impossible, especially among the Indians who continually wander back and forth across the international frontier.

DUTCH DRIVERS

The Dutch police stopped 35,955 motorists in the first weekend of enforced breath tests. Of the total, only 317 were judged by the police to be in need of the breath test, and 92 of these were forced to hand over their keys and walk home. This seems to indicate a small drinking-driving problem in The Netherlands, but this will not be confirmed until more figures are available.

NON-SMOKERS SHY

A recent Japan Times editorial notes with dismay that while a number of voluntary no-smoking campaigns are underway in various parts of Japan, the average Japanese non-smoker is still afraid to ask the smoker to extinguish his cigarette in places where it is not only unpleasant, but completely forbidden to smoke. The article warns that recent medical evidence suggests non-smokers can also be damaged by the smoke in smoke-filled rooms, and not complaining because of timidity or politeness is no longer a very good policy. The article calls for greater consideration of the rights of the Japanese non-smoker.

Bavarian habits

MUNICH—Half of Germany's young people between 12 and 20 years of age drink some form of alcohol each day or more than once a week, according to a survey by the Infratest Institute here.

The survey was commissioned by the Interior Ministry and covered about 1.8 million youngsters living in Bavaria, which of course, is world famous for its beer.

Fifteen per cent of those questioned said they regularly drank hard liquor, including whiskey. Most alarming to the authorities was that 25% of those aged 12 to 14 regularly drank, beer, wine or the German champagne, Sekt, and 5% of this young group drank "hard" drinks.

Among the 15-to 17-year-olds, the figures were 38% and 13%, respectively.

Youngsters' drinking habits closely correlated with their parent's consumption of alcohol. The survey showed that the more hardened young drinkers came from families where mother and father drank habitually.This tendency was strongest among the youngest people.

Regular smokers also came from families where one or both parents were heavy smokers. Thirty per cent of the young people in Bavaria smoke, and more than 47% in the 15 to 17 age group smoke.

About 95% of the young favor cigarettes, and 57% already smoke more than 10 per day. Eight per cent smoke 30 or more per day.

Medical 'grid' pinpoints problem signs

Excessive drinkers can be spotted at early stage

By LYNN PAYER

PARIS — Habitual excessive drinkers can be detected medically at a stage where 60% can be persuaded to diminish their intake of alcoholic beverages, Dr. P. M. Le Gô of the French Ministry of Health, said in an interview here.

The detection is accomplished by means of a grid or chart upon which the examining physician ranks several pertinent signs during the course of a physical examination. It requires only a few minutes. Dr. Le Gô told **The Journal**.

He emphasized the grid was to be used for the screening of apparently healthy subjects and not of suspected alcoholics, for whom it would be unnecessary.

"Long experience has shown that even the best-trained physician will not be able to detect the number of intoxicated subjects that the grid will," Dr. Le Gô said.

He said the method was particularly useful in a wine-producing country such as France where people become alcoholic not because of any psychiatric disorder, but by habitual drinking over a period of years. About 80% of chronic alcoholics in France fall into this group, he said.

"I would think, however, the method would still be valuable, though perhaps less so, in non-wine producing countries," he said.

The grid was developed by Dr. Le Gô and his co-workers while he was working as a physician for a section of the French railroads. It was begun in the 1950's, when a post-war wave of alcoholism was hitting France.

While the grid was originally developed to follow the evolution of known alcoholics, it was later modified to take account of the earliest signs. It has been used by 60 physicians, in more than 50,000 subjects, over a period of 20 years.

The grid consists of 12 compartments. In the first six, constituting the top line, the aspect of the face, the conjunctiva, and the tongue; and the trembling of the mouth, the tongue, and the extremities, are rated from 0 to 5.

On the bottom line, subjective problems with nervousness, digestion, or coordination, including accident-proneness, are noted as are the condition of the liver, the weight and height of the patient, and the blood pressure.

Dr. Le Gô and his colleagues have long-term studies showing that obesity and high blood pressure are often associated with habitual drinking. If the obese, hypertensive subject is also accident prone, there is at least one chance in two that he is ethylique, according to Dr. Le Gô. If the subject stops drinking, his chronic hypertension also disappears.

"This fact is so well established in the eyes of the French railroad physicians that they will not believe a patient who claims to have stopped drinking if this high blood pressure persists," he said.

A healthy person should have a ranking of zero on the grid, although a ranking of 1 is not sufficient in itself to lead to a diagnosis of excessive drinking.

Several signs ranked 1, however, interspersed with zero's, usually do indicate the first signs of heavy drinking, Dr. Le Gô said. He added, however, that the grid should not be used as a definitive diagnosis.

Once an excessive drinker has been identified, he can often be persuaded to moderate his intake by being shown that alcohol has already caused a deterioration of his physical condition, Dr. Le Gô explained. This is often best accomplished by persuading the patient to abstain from alcohol for a certain period of time, he said.

"Since most of these habitual drinkers are not yet dependent on alcohol, there is no need for complete abstinence for the rest of their lives, however."

To carry out the follow-up diagnosis and treatment of people identified as habitual drinkers by means of the grid. France has recently authorized the establishment of Centres d'Hygiène Alimentaire (CHA), so-named to overcome the stigma of alcoholism but also to reflect the fact that most drinking in France is more an alimentary error than a psychiatric one. Approximately 40 public CHA, as well as about 20 private ones in industry, are being started, Dr. Le Gô said.

A limited supply of pamphlets, "le dépistage précoce des buveurs d'habitude", and the comparison chart of the same name, are available from Dr. Le Gô.

Professionals often ill-prepared for encounter with drug addicts

By DOROTHY TRAINOR

MONTREAL—The orientations of the drug addict and his professional counsellor are widely divergent and neither training nor previous experience, may have prepared the counsellor for this unique encounter.

This topic was addressed by Dr. Harvey Weiner here at the Canadian Society of Clinical Pharmacology and Chemotherapy. Dr. Weiner, DSW is clinical coordinator of the large and centralized Drug Abuse Rehabilitation Program of West Philadelphia, Pa.

"Furthermore," said Dr. Weiner, "the worker in the methadone program becomes a part of the controversy surrounding this drug."

How does one reconcile the disparate ideologies of the drug addict and the social worker or other professional therapist? How does one resolve the difficulties inherent in this treatment situation?

The questions are key ones for the professional: Non-professionals are often far more successful, he said.

"The addict entering treatment has organized his life around immediate gratification of impulsive needs. His objectives in the program are often at the same level.

"Methadone is the tangible, concrete substance that will satisfy his craving for opiates. 'Talk therapy' is the game one plays to get the drug.

"In most treatment settings, patients recognize they are having personal and/or social adjustment problems. They are willing to talk about them. The addict coming into treatment rarely sees any value in the talk therapy. Indeed, many have had unsuccessful experiences with this type of treatment."

In addition to these obstacles, Dr. Weiner said, the professional is usually denigrated in the addict's view to a do-gooder with knowledge limited to books.

So, the stage is set for conflict. The professional enters square one. His objective is somehow to encourage in the addict a longer range point of view, which will be necessary for his personal and social rehabilitation.

That counsellor should recognize at the start, Dr. Weiner advised, that the addict has had to undergo a drastic change in lifestyle.

"Waking up in the morning without having immediately to think of a fix is a new experience. New patients are often unable to think about personal and social rehabilitation until they are stabilized physiologically, which usually takes one to three weeks.

Harvey Weiner

"Another problem is that the new patient is being asked to enter into a counselling relationship based on trust and long-range goals. In his former subculture life, the addict's personal relationships have been characterized by distrust and immediate indulgence."

A basic paradox of methadone treatment, he said, is that it fosters a classic love-hate relationship.

"The patient loves the program because it encourages independence and frees him from heroin dependence. He hates it because of his new dependence on methadone and the control the program exercises over his life."

The program may also involve a love-hate duality because of the *authority* invested in the worker's role.

"Nonetheless, this authority should be recognized as a prime dynamic. Affirmation of this authority lends structure to the counselling relationship and facilitates rehabilitation."

The therapeutic necessity of the worker's authority must be recognized by both worker and patient. It becomes part of the contract which clarifies roles, the patient's expectations, and those of the program.

Despite this authority, Dr. Weiner said, the skill of the worker will be seen in the dignity and respect demonstrated for the patient. It is important to show the addict that he cares; that the authority inherent in his role will be used to help towards treatment goals.

"Trust has to be earned by both parties to this contract. If the worker avoids or minimizes these aspects, the counselling relationship will be seen by the addict as dishonest."

The patient is ambivalent about giving up the world of addiction, Dr. Weiner said, because in it he has known some success. He is caught in a struggle between desire to move towards health, and fear of leaving the addict world. The importance of that subculture cannot be minimized.

The counsellor must also get across to the addict that program controls are protective and positive and aim to help by establishing the inner control that he is lacking. Urinalysis represents a reality both addict and worker understand.

"Urinalysis results are used by the counsellor to detect illegal drug use so this can be discussed, and the patient encouraged to look at why he continues to turn to drugs."

How far is the worker committed to holding the patient to treatment goals?

"It should be clear the worker may have to recommend the patient be placed on probation or even terminated from the program. The worker must demonstrate he can be trusted with this prerogative. The addict may have had unpleasant experiences in situations involving an abuse of authority."

Unfortunately, sometimes the patient-therapist relationship approaches the stage of actual physical confrontation.

"Because bullying and violence are so much a part of the 'ripping and running' of the drug culture, workers are sometimes subjected to personal threats of violence.

"Male addicts have difficulty with sexual role identification, resulting in frequent displays of machismo and a tendency to react aggressively to perceived threats to their masculinity. Female addicts who have had to hustle and defend themselves against violence are also prone to violence."

A regrettable aspect of this therapeutic scenario, said Dr. Weiner, lies in personal satisfaction—or lack of it—on the part of the professional worker.

Improvement is often incremental and not noticeable for months or years. The professional must also face the possibility of seeing his patient become readdicted even after he has been stabilized by methadone and made substantial progress.

"The addict usually has little formal education, an unfortunate lifestyle, a criminal record and a poor work history. People with poor job skills have little chance of finding decent employment."

Not only would a job for the ex-addict enhance his battered self-image, it would also enable him to use his time constructively instead of facing the perils of "hanging around".

"The inability of society to provide meaningful jobs and/or training opportunities often result in readdiction."

....More letters

Sir:

Every time I read, as I did in the December issue of **The Journal** (N.B.'s war on drinking drivers) about some province or authority making bold, ringing statements about running the drinking driver off the road, I can't help getting a little worked up.

As an ex-newspaper man, specializing in police and court reporting, and a former member of my local safety council, I am utterly convinced the only protection we, the innocent, will ever truly have from the drinking driver will be heralded by a radical redefinition of society's concept of criminality.

In my view, a drunken slob who aims three tons of metal down a crowded highway at me, my wife, and innocent baby, is guilty of conduct far more "criminal" than the petty hood who relieves a fat grocer of $100.

Yet, in our provincial courts, the drunk will likely escape with a $150 fine and a three-month licence suspension—often regardless of whether or not he kills—while the armed robber who has harmed no one and committed a crime only against *property* may receive a prison term of several years.

Only when our politicians have the guts to stand up and prescribe mandatory jail terms of at least 14 days for all convicted drinking drivers, will the message get through.

The present fine of $150 in the Ottawa area is a farce. It's the same penalty whether you are an unemployed father of six or a wealthy businessman with a six-figure income.

Provincial Court judges must bear a great deal of the responsibility for the slaughter on our highways caused by alcohol: They have the power to jail on first offence but I have never heard of such a case.

It's all just part of an attitude of laxity and permissiveness which is the main reason our society is going down the drain.

If a drunk driver killed an innocent family and I were on the bench, I'd only regret I didn't have the power to send him to the gallows.

J. M. Bryan,
Former court reporter,
Ottawa.

Heroin

Sir:

In your November 1, 1974, issue of **The Journal** in the article entitled "Heroin use endemic and spreading" by Milan Korcok, it was stated that the San Francisco City Methadone Program had 400 patients in December and in July had 600 patients. That is not true. The actual figures are 693 in December and 782 in July.

In general, we have found for the last several years that the number of clients is limited by the number of treatment slots available, our ability to process people through intake, and the availability of street heroin.

Lee L. de Barros
Director of Research Evaluation
Community Mental Health Services
Department of Public Health
San Francisco

Vancouver

Sir:

In your lead article on narcotics use in British Columbia in the December issue of **The Journal**, you quote Mr. McDonald, the Vancouver coroner, to the effect that "since 1970 Vancouver has had more than 1,000 drug-related deaths."

While technically correct, in the context of an article about narcotics, this statement could be misleading especially in view of the fact that Mr. McDonald was previously misquoted in a Southam News Services article (*Ottawa Citizen*, Nov. 4, 1974, p. 7) to the effect that "there have been more than 1,000 *hard* drug-related deaths in Vancouver over the past four years" (emphasis mine).

For the information of your readers, the study referred to by Mr. McDonald was one supported by our Directorate. The investigator examined the Vancouver coroner's records from 1970-1973.

The following were some of the major findings:

(1) A total of 987 "drug-related" deaths were reported during the four years;

(2) Alcohol, alone and in combination with other drugs was by far the most frequently involved drug (72% of cases), followed by barbiturates (34%) and then narcotics (18%);

(3) The number of "drug-related" deaths did not vary much from year to year (1970-247; 1971-223; 1972-267; 1973-250);

(4) The number and rates of alcohol-related, barbiturate-related and narcotic-related deaths was fairly stable over the four years;

(5) The highest incidence of deaths involving narcotics was reported in 1972 with a decrease in 1973;

(6) Of the total sample of cases, slightly less than one-third (27%) were judged to be "alcoholics" at the time of death and about one-sixth (17%) to be "drug addicts";

(7) The proportion judged to be "drug addicts" was greatest in 1972 (23%), declining in 1973 (to 18%);

(8) Deaths were judged to be the direct result of drug usage in about two-thirds of the cases and indirectly involved in the remaining third. Of those judged to be "alcoholics", slightly more than half (54%) of deaths resulted directly from the use of drugs as compared to 95% in the case of drug addicts."

Among other things, these findings suggest that the incidence of "drug-related" deaths in Vancouver has not increased dramatically over the past four years and that the incidence of narcotics-related deaths, after peaking in 1972, has started to decline. It also suggests that alcohol is probably far more important than narcotics as a contributory factor in deaths.

I trust that this summary of findings will give your readers a better perspective on the meaning of your quotation.

Irving Rootman, Ph.D.,
Chief, Epidemiological and Social Research.
Non-Medical Use of Drugs Directorate
Ottawa, Ontario K1A 1B6

'Sexual'

Sir:

A recent article by Carolyn Holstein, "Drug users have more sex with more people." (November 1974) struck a note of interest. The article states: "In contrast, said Dr. Piemme, methadone users say 'sex is as good as ever'."

The statement is of interest in that it runs contrary to our clinical observations and the *preliminary* results of our research on the effects of methadone on sexual activity.

Dr. Andrew Weil in his book The Natural Mind stated that often times when similar research yields contradictory results, the researchers may well be asking the wrong questions. Perhaps it is time to review our questions, and basic assumptions.

Steve Saxon, staff psychologist and
Charles P. Dennett, director
Solana Beach Clinic
Solana Beach, California

WHAT KIND OF SMOKER ARE YOU?

HOW TO SCORE:

Enter the numbers you have circled in the spaces below over the appropriate letters. Then total the scores on each line to get your totals. For example, the sum of your scores on lines A, G & M gives you your score on stimulation. Lines B, H and N give the score on handling etc.

Scores can vary from 3 to 15. Any score 11 and above is High. Any score 7 and below is Low.

A + G + M = Stimulation

B + H + N = Handling

C + I + O = Pleasurable Relaxation

D + J + P = Tension Reduction

E + K + Q = Psychological Addiction (Craving)

F + L + R = Habit

(Answers to questions on page 5)

District of Columbia pot smokers let off the hook...well almost

WASHINGTON—The District of Columbia almost—but not quite—instituted a "no prosecution" policy for possession and use of small quantities of marijuana.

U.S. Attorney Earl J. Silbert, made famous by his initial efforts to prosecute the Watergate burglars (and criticized for carrying the investigation no higher), made headlines again last month when he unilaterally announced that D.C. prosecuters would not act against people arrested for personal possession and use.

The decision was made at about the time Dr. Robert L. DuPont, chief White House expert on drug abuse, said in a speech that he believed prison sentences for using marijuana were wrong.

Dr. DuPont backed down a few days later and "clarified" his earlier remarks. He said neither he nor the Ford Administration favored abolition of legal penalties for marijuana use.

Mr. Silbert, too, backed down from his position, which had been attacked by metropolitan police department officials and conservative columnists like William Safire of the New York Times.

Mr. Safire, for example, wrote: "Because this announcement comes as a welcome relief to many who do not like to see young people 'busted' for participating in a prevailing custom, nobody takes notice of a remarkable precedent being set."

That precedent was that the executive branch was deciding which laws to enforce and which to ignore, he said.

Actually, the policy received support, too. D. C. Superior Court Judge Harold H. Greene said he felt it would lessen the court's growing logjam of misdemeanor trials, which had jumped from 928 to 1,485 in a 12-month period.

"I just think the resources of the police, prosecutors and courts are limited," Greene said, "and we should concentrate on the violent crimes that are more important."

Only about half the 1,500 marijuana cases that entered the D.C. Superior Court system went to trial.

But, pressure from the Justice Department was more persuasive in the end. "I do not condone illegal marijuana use and I do not want to do anything that would in any way suggest that the law of the United States should not be fully observed," said a statement issues by Silbert's office three weeks after his original announcement.

U.S. Attorney General William B. Saxbe, early this month, added his own views: "This is already a substantial problem. It would grow worse if the ban were to be eased."

Public pressure expected to curb tobacco smoking

TORONTO—The public can probably do more to curb tobacco smoking than a government ever can, believes federal health minister Marc Lalonde.

At the annual meeting of the Ontario Hospital Association, he predicted there would be increasing public pressure for non-smoking areas to protect the rights of non-smokers.

He urged hospitals to play a greater role in public education to promote health and prevent disease, and to practice what they preached.

While he wasn't advocating that smoking in hospitals be banned—"That's up to them"—he thought they should set aside more specific smoking areas now that there is greater awareness of the health dangers in smoking.

"Even in schools and hospitals, in board rooms and concert halls, tobacco has long been established as a right. Now, the greater emphasis on preventive measures and risk reduction to improve the nation's health, increases the hospitals' dilemma. I urge the hospitals to assume new responsibility in promoting these ends. . . ."

He said smoking has always been banned in some hospital areas like operating rooms, but "smoking in lounges, coffee shops, washrooms and patient rooms is considered sacred and an inviolable right".

Anti-smoking programs aimed at hospital staff "hold promise for the future", and some hospitals have established smoking and non-smoking areas.

"The time is now for every segment of the health care field to accept the challenge and responsibility of helping to reduce the hazards to health inherent in smoking.

"This is only one instance of how skilled personnel can establish programs and set examples through their own lifestyle which could, inevitably, succeed to a considerable degree, in modifying behavior and improving the level of health of those they serve."

Unborn babies

(continued from page 1)

there are dosages of LSD that are astronomical. . . . Some tissue cultures have been given enough to destroy neurons for 300 years. A similar concentration of Paplum would give similar results."

In another study, there were 96 congenital malformations per 1,000 births instead of the five to 10 expected. The mothers had taken LSD, but were all using other drugs, as well as living in the drug environment. "There's no question something was wrong, but that doesn't finger LSD specifically.

"The conclusion on chemicals is that we don't know about chromosomal breaks or congential abnormalties. But we do know if the mother is part of the drug-using culture, she is going to have trouble."

Dr. Anderson said intravenous amphetamines cause greater damage to the individual than any other drug, including narcotics, and they are the most prevalent hard drug in Ontario.

"It's unusual to find a chronic speed user getting to term pregnancy. In fact, it's hard to imagine some of them having intercourse. They probably lose the fetus early in pregnancy."

The biggest narcotic problem in obstetrics is the fantastic increase in the number of infants born addicted, Dr. Anderson said. In 1960 in one New York hospital, the rate was one addicted for every 164 births. In 1972 in the same hospital, it was one of every 27.

Yet pregnancy is probably infrequent among heroin addicts because they rarely have normal menstrual function. Reproductive function does not appear to be interfered with by methadone. It can also produce false positive pregnancy tests.

Babies of methadone mothers often show withdrawal symptoms, and at least half of them have mild symptoms, he said. These may return in one to two weeks, with convulsions and respiratory distress.

"Stoned" driving is unpleasant, say marijuana smokers

VANCOUVER—The majority of volunteers who took part in a two-year study here on the effects of marijuana on driving, say drivers should be as wary of marijuana as they are of alcohol.

Only 12% of the volunteers, answering a questionnaire as part of the extensive study, said no precautions should be taken.

Most said that in their private lives, they had smoked marijuana or used marijuana in combination with alcohol before driving.

The study, by Professor Harry Klonoff and a team of researchers at University of B.C., included testing the driving ability of volunteers under the influence of marijuana, in downtown Vancouver traffic.

The major finding (The Journal, November 1, 1974) was that marijuana and driving are as dangerous a combination as alcohol and driving.

However, answers by volunteers to a lengthy questionnaire and in interviews, provide additional insights into the results.

The volunteers, male and female, were young and the majority were either university students or professionals. As a condition of the study, all had previously smoked marijuana.

After smoking marijuana and driving in the study, volunteers were asked: "Would you have driven on city streets being as stoned as you are, if you had not been participating in the test situation?"

By PETER THOMPSON

Forty-two per cent answered yes, 37% said yes but with reservations, and only 21% answered no.

While driving, volunteers were asked how they felt, Dr. Klonoff said 72% of volunteers' replies indicated it was an unpleasant experience.

Of the 64 subjects, five reported that their driver's licence had been suspended in the past. One had been suspended for reckless driving, another for being impaired, and three for other reasons.

Answering questions on their previous driving habits, 80% said they had driven *after* smoking marijuana and 55% said they had driven *while* smoking marijuana.

Thirty-eight per cent said they had been driving *after* smoking marijuana for a period of three years, and another 28% said they had been doing the same for one year.

Forty-two per cent said they had smoked *while* driving for three years. Frequency, over the past year, of driving after smoking was about once a month. The frequency of driving while smoking was less.

The volunteers reported driving while smoking in daylight hours as well as at night.

Part of the questionnaire was to determine the amount of marijuana used in association with driving and the effects the volunteers said it had.

The most common amount smoked before driving was reported to be slightly more than one joint. Slightly less than this amount was smoked while driving.

Sixty per cent reported that their driving experience was unpleasant, with characteristics such as anxiety, less attentiveness, slower reflexes, lack of control, poor judgement, and being bothered by light.

Sixty-one per cent of the volunteers, Dr. Klonoff said, "reported that marijuana slightly detracts from or impairs driving".

Another part of the questionnaire dealt with restrictions on driving while under the influence of marijuana or other drugs. The volunteers were asked: "If marijuana is legalized should there be precautions regarding marijuana and driving?"

Twelve per cent were undecided and another 12% said there should be no restrictions, while 60% said the restrictions should be as they are with alcohol and 16% said there should be other restrictions.

Of the group, 28% said they had used other drugs in combination with marijuana before driving and 13% while driving.

Propranolol neither helps nor hinders narcotics withdrawal, studies suggest

PARIS—Propranolol has neither an antagonist action on narcotics, nor does it ameliorate the course of withdrawal from them, Dr. L. E. Hollister, Veterans Administration Hospital, Palo Alto, California, told the Collegium Internationale Neuropsychopharmacologicum.

"Propranolol is not a very useful drug in the treatment of narcotic addiction," Dr. Hollister said. "It may be useful in patients whose addiction is not strong, but this could be handled by other means."

His conclusions were reached after three studies. Although the first two open studies indicated propranolol might be effective, the third, which was double-blind, showed no effect.

The studies were started, Dr. Hollister said, following suggestions in the Letters section of *The Lancet* that propranolol was a narcotic antagonist. Other investigators were reporting it was useful in helping withdrawal from alcohol.

"One would expect propranolol to aggravate withdrawal reactions from opiates if it were a narcotic antagonist, but it might ameliorate these if it lacked this effect," he said.

In the first study, 19 patients being detoxified from opiates were treated in an open study, receiving 160 mg daily of propranolol and methadone as needed.

"These patients generally required less methadone for successful detoxification than did those treated immediately prior," Dr. Hollister said.

A second study suggested propranolol also decreased methadone requirements. However, "we later concluded this was an artefact due to lessened dependence in these patients."

In the third, double-blind study: "No differences were found between patients treated with propranolol or placebo in their requirements for methadone for adequate detoxification," Dr. Hollister reported.

Following his presentation, two members of the audience said they had done similar studies on propranolol, with similar results.

Sports report

TORONTO—The use of drugs by athletes to improve performance is a serious problem and should be curbed, a report to the Toronto Board of Health by the city's mental health director has recommended.

Director E. D. Wong suggests rigid fines and suspensions should be imposed by sports groups, team owners, and managers, to deter athletes from non-medical drug use.

The report, to be referred to federal and provincial governments for action, will also go to local boards of education as it calls for education programs on the hazards of drug use.

Book Report

The following books have recently been acquired by the Addiction Research Foundation library in Toronto. These books are not for sale at the library, but general enquiries may be directed to The Library, 33 Russell Street, Toronto, Ont. M5S 2S1 (595-6144).

Phoenix House: Studies in a Therapeutic Community (1968-1973): De Leon, George (ed.) MSS Information Corporation, New York, 1974, 214p., $17.

Studies of the Effectiveness of Treatments for Drug Abuse: Vol. I: Evaluation of Treatments: Sells, S. B. (ed.) Ballinger Publishing Company, Cambridge, 1974, 534p.,

Studies of the Effectiveness of Treatments for Drug Abuse: Vol. II: Research on Patients, Treatments and Outcomes: Sells, S. B. (ed.) Ballinger Publishing Company, Cambridge, 1974, 418p.

Behavioral and Social Effects of Marijuana: MSS Information Corporation, New York, 1973, 175p., $17.

Marihuana: Biochemical, Physiological and Pathological Aspects: MSS Information Corporation, New York, 1973, 289p., $17.

Immunoassays for Drugs Subject to Abuse: Mule, S. J., Sunshine, I., Braude, M., and Willette, R. E. (eds.) CRC Press, Cleveland, 1974, 126p., $25.64.

The Treatment of Alcoholism: Theory, Practice, and Evaluation: Larkin, E. J. Addiction Research Foundation, Toronto, 1974, 73p. Program report series no. I: causes and cures: disease concept: treatment programs: termination: behavior modification: evaluation of programs.

An Alcoholic in the Family: Burton, Mary. Faber and Faber, London, 1974, 175p., $5.39.

Accreditation Manual for Alcoholism Programs: Joint Commission on Accreditation of Hospitals, Chicago, 1974, 86p., $4.50.

Drug Experience, Attitudes, and Related Behaviour Among Adolescents and Adults: Abelson, Herbert, Cohen, Reuben, Schrayer, Diane, and Rappeport, Michael. Response Analysis Corporation, Princeton, 1973, 191p. Part I, main findings: "a nationwide study for the National Commission on Marihuana and Drug Abuse."

A Treatment Model for Acute Drug Abuse Emergencies: Bourne, Peter G. (ed.) U.S. Government Printing Office, Washington, 1974, 178p., $2.15.

Therapeutic Effectiveness of Methadone Maintenance Programs in the Management of Drug Dependence of Morphine type in the U.S.A.: Wilmarth, Stephen S., and Goldstein, Avram. World Health Organization, Geneva, 1974, 53p., $3.

The Breathalizer Legislation: An Inferential Evaluation: Carr, B. R., Goldberg, H., and Farber, C. M. L. Information Canada, Ottawa, 1974, 118p., $1.50.

Social Aspects of the Medical Use of Psychotropic Drugs: Cooperstock Ruth (ed.), and Lambert, S. L. (gen. ed.). Addiction Research Foundation, Toronto, 1974, 179p. Papers presented at the International Symposia on Alcohol and Drug Research.

Research on Methods and Programs of Drug Education: Goodstadt, Michael (ed.), and Lambert, S. L. (gen. ed.). Addiction Research Foundation, Toronto, 1974, 191p. Papers presented at the International Symposia on Alcohol and Drug Research.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

National Clergy Conference on Alcoholism and Related Drugs—Jan. 6-10, Miami. Information: Rev. John P. Cunningham, 2749 N. Marshfield, Chicago, Ill. 60614.

Midwest Institute of Alcohol Studies—Jan. 26-31, Kalamazoo, Michigan. Information: Jean Wright, Division of Continuing Education, Western Michigan University, Kalamazoo, Michigan 49001.

Southeastern Conference on Drug Use/Abuse—Intervention/Prevention—Feb. 20-22, Atlanta, Georgia. Information: Dr. T. J. Gleaton, P. O. Box 313, Georgia State University, Atlanta, Ga. 30303.

31st International Congress on Alcoholism and Drug Dependence—Feb. 23-28, Bangkok. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Recent Advances in the Management of Alcoholism and Drug Addiction—March, Toronto, Ont. Information: The Director, Division of Post-graduate Medical Education, University of Toronto, Toronto, Ont. M5S 1A8.

Postgraduate Day on Clinical Pharmacology—Antimicrobial Drugs—April 5, Toronto, Ont. Information: The Director, Division of Postgraduate Medical Education, Faculty of Medicine, Medical Sciences Building, University of Toronto, Toronto, Ont. M5S 1A8.

Sixth Annual Scientific Conference of the National Council on Alcoholism—April 28-29, Milwaukee, Wisconsin. Information: George C. Dimas, National Council on Alcoholism, 2 Park Avenue, New York, N.Y. 10016.

Institute on Crime, Justice and Heroin—May 19-June 3, London, England. Information: Dr. A. S. Trebach, Centre for the Administration of Justice, The American University, Washington, D.C. 20016.

21st International Institute on the Prevention and Treatment of Alcoholism—June 9-15, Helsinki, Finland. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Third International Conference on Drug Abuse—Sept. 1-5, London, England. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

First National Conference on Occupational Alcoholism and Drug Abuse—Sept. 22-25, Etobicoke, Ont. Jointly sponsored by Humber College and Addiction Research Foundation. Information: Jim Simon, A.R.F., West Toronto Branch, 4143 Dundas St., W., Toronto, Ontario M8X 1X2.

International Conference on Alcoholism and Drug Dependence—Oct. 26-Nov. 1, Sao Paulo, Brazil. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Symposium on Alcohol and Drug Dependence—Nov. 29-Dec. 5, Bahrain, Arabian Gulf. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Drinking drivers may face mandatory medical examination

LONDON — A compulsory medical examination has been proposed by the Royal Society for Prevention of Accidents here for any driver, convicted by a court, who has a drink problem.

The proposal has come from the society in its evidence to a Government committee now reviewing Britain's drinking and driving legislation.

Under the society's plan, the court could order a driver to have a medical examination if it determined he had a serious drinking problem and if he was brought before the court for driving with more than the legal maximum of alcohol in his blood.

A medical examination would be mandatory if the blood alcohol level was higher than 150 mg per 100 ml of blood or where there is a second offence. The legal limit is 80 mg per 100 ml.

The driver's licence would then be withdrawn and not returned until it was decided he had been treated successfully for his alcohol problem.

Positions Available

Beer tops U.K. consumption poll

LIVERPOOL, ENGLAND—Britons consumed some 61.4 million gallons of absolute alcohol during 1973, according to calculations made by the Merseyside Council on Alcoholism here.

The estimate of absolute alcohol consumption is based on the assumption that all beers contain an average 3% absolute alcohol, all wines 12% absolute alcohol, and all liquors 57%.

Mr. William Kenyon, council director, said that calculating drinking on the basis of this figure gave a much better picture of consumption in this country.

Surprisingly, he said, beer still comes out as the biggest source of absolute alcohol last year—39.5 million gallons. This was followed by 14.1 million gallons of absolute alcohol from liquors and 7.8 million gallons from wine.

Mr. Kenyon said three factors indicate the prevalence of alcoholism in Britain has risen dramatically since 1969—consumption, drunkenness offences and hospital admissions of drinkers.

Drunkenness offences have risen from 80,502 in 1969 to almost 100,000 in 1973 and proceedings against motorists for drunken driving in the same period have increased from 29,427 to more than 66,000 cases.

Hospital admissions for alcoholism and alcoholic psychosis rose from 9,141 to 14,007 in the same five-year period.

"Release"

'Underground' organization sparked by UK Stones' fans

By ALAN MASSAM

LONDON—The word "Release" is stuck in paper cut-out letters on the door, otherwise one could easily miss the crumbling Victorian mansion that is the headquarters of Britain's largest "underground" organization

Inside is a wooden staircase, threadbare floor covering, pictures on the wall, appeals for working class unity, and other signs of "youth culture". A poster says: "Cannabis is a herb".

Upstairs is where the action is. Young men and women, in sweaters and jeans, are busy talking, telephoning, writing. Some are clients, or "customers" as Release workers prefer to call them; some are members of the staff. Distinguishing the helper from the helped—visually at least—is not always easy.

Release exists to "help young people in difficulties" and handles 400 inquiries a week.

When it started, in 1967, the emphasis was on sorting out the problems of youngsters charged with drug offences and "whose unorthodoxy and dissent, long hair and unconventional dress, were often met by public prejudice and police harrassment".

The impetus came from the anger felt by many young fans of the Rolling Stones pop group after its members had been charged with alleged cannabis offences. Britain's largest Sunday newspaper, the News of the World, ran the story prominently and a demonstration of Rolling Stone supporters was staged outside the newspaper's London offices. From this demonstration Release was born.

Since then, as one of the workers, Don Aitken, explains, the tendency has been to look beyond the drug problems, to tackle all the associated difficulties in a practical way, and essentially, to offer friendship, support and advice to those who seek it.

To-day Release operates exclusively from its headquarters in Elgin Avenue, West London (1 Elgin Av London W9 3PR Tel 01-289-1123) and has no branches in any other part of Britain.

A spokesman for the organization told **The Journal**: "We are essentially an informal group. Of course we have contacts with sympathetic doctors and solicitors in towns throughout the country. If we get calls for help from anywhere in Britain we can usually advise the caller whom to approach. This service is provided at all times through our 24-hour telephone service."

One of Britain's best-known sociologists, Michael Schofield, says anyone who spends more than a few hours at Release will find the work compelling and self-evidently important.

Although Release's clients sometimes get the same advice as they might receive from the statutory social welfare agencies "the difference is that in the latter situation they would be inclined to reject this advice", says Mr. Schofield.

"Coming from someone with a similar life style, they find it more acceptable," he says.

Aitken estimates that as many as 75% of the clients who seek aid from Release are too alienated from "straight" society to be reached by the statutory agencies (e.g. probation officers, Citizens Advice Bureau and local authority social workers).

In fact, Release workers quote the definition used in the Le Dain report to explain the unique contribution such voluntary organizations can make.

Le Dain said "straight" organizations were "too rigid, impersonal, detached and often too committed to traditional values to respond to the unique problems of this generation".

They were often "characterised by punitive and condescending attitudes and excessive professionalism. Bureaucratic and formal procedures are dehumanising; they embrace conventional middle class morality with its work ethic, sexual propriety, cleanliness and moderation. . . ."

Release's amateur, but essentially dedicated and effective approach, is the complete contrast.

Its activity can be divided into three main categories—legal, medico/social, and proselytizing.

On the legal front it has three full-time counsellors who advise those charged with drug offences, people with immigration problems, tenants in difficulties with landlords, and individuals who have complaints against the police.

This consists largely of referral to sympathetic lawyers, but on two nights every week the Release headquarters have solicitors on the premises to help those needing immediate professional aid.

One unique service offered by Release is its assistance to people arrested for drug offences abroad.

Says Aitken: "Arrest in a foreign land where the language and customs are unknown is always a difficult and usually a desperate situation. We employ one full-time worker who collates information about foreign legal procedures and advises bewildered relatives of newly-arrested people about what to do to help them.

"We also write to prisoners, send them magazines and books as a way of boosting their morale, and send medical supplies which are often urgently needed."

An extension of this work has been the publication of the Release guide to avoiding trouble when travelling abroad, the Trucker's Bible.*

Medico/social work includes a pregnancy section which offers help with referrals for abortion, advice on contraception and adoption, and support for single mothers. This department uses the counselling of a full-time psychiatric social worker.

"At present, we offer advice, information, and counselling on family, marital, personality or sexual difficulties: psychiatric treatment, and alternative psychotherapies," says Aitken.

There is also psychiatric and medical help for people dependent on drugs, patients attending hospitals for mental illnesses, and "runaways".

"People use Release as a sounding board, to test out other possibilities of help, or to assess whether or not their rights are being infringed," says Aitken.

"Their faith allows us to provide an immediate and continuous service offering support, reassurance and short-term therapeutic relationships under conditions of maximum informality and availability."

Both the medical and legal arms of Release can be effective at any time. The agency's 24-hour telephone answering service deals with all emergencies outside office hours (10 am to 6 pm Monday to Friday).

Release workers like Don Aitken refer to the agency's proselytizing as "education and press liaison." Its views on cannabis, however, are sometimes expressed in propagandist terms.

An explanatory leaflet, What's Release? says: "Release's own experience with a great number of cannabis smokers has led us to the inevitable conclusion that there should be no criminal or civil penalties for cannabis possession or use and that serious consideration should be given to realistic measures of supply and control.

"A considerable amount of medical research has failed to identify any serious adverse physical or mental effects resulting from cannabis use.

"The Release position is based not only on available medical evidence, but also on the fact that the harm caused by enforcing cannabis laws far outweighs the supposed social benefit to be derived from the vigilant implementation of these laws.

"Not only are the cannabis laws used as a method of harassment against young, long-haired, and black members of society, but the effects of cannabis law enforcement have resulted in a genuine distrust of laws, lawmakers, and the police."

Another sociologist, Jeremy d'Agapayeff, reported after studying Release that its caseload of welfare work was divided into three categories—arrests, 38%; pregnancy advice, 21%; and "other legal and medical advice", 41%

People ranging in age from 14 to 60 years sought help from the agency, but most (68%) fell into the aged 18-24 group. Twenty one per cent of the "customers" seen while Mr. d'Agapaveff was doing his study, gave a local address, thus emphasizing Release's role of serving its immediate community.

Altogether, 55% came from within the London postal district area and a further 10% lived in the adjacent Home Counties, showing that Release was predominantly London-area oriented.

But 27% of the people given help lived well outside London or came from abroad, indicating that the organization also reached out to a wider geographical area.

Clients who could be identified by class analysis were divided into the middle and working class categories at 52% and 48% respectively, thus discouraging any idea that Release was a "self-indulgent middle-class organization".

Mr. d'Agapayeff concluded that self-help was a vital part of the Release philosophy and it was for this reason that it had tended to recruit staff from the community it served. This was done by "utilizing a direct, personal, empathetic and immediate approach".

Being seen as part of the community was essential for the maintenance of Release's credibility. People sought help from the agency because they trusted it. If they had any doubts they would cease to come. The staff had been described as 'welfare rights advocates' who took up the causes of others who were in difficulties.

Release is linked with a number of "alternative" groups who might act as agents for the organization up and down the country. But they all remain autonomous and are not controlled by Release in any way.

This also applies to a number of organizations also called Release or similarly-named throughout Western Europe. A Release spokesman said: "Most of these were modelled on our experience and we maintain friendly links with them. But they are in no way controlled by London Release and in many cases have evolved different roles."

Sex and drugs advice for youths

NOTTINGHAM, ENGLAND—A centre called "Off the Record", which will offer advice to young people on drugs and sex, has opened here.

The centre sponsored by the Nottingham County Council, is staffed by people ready to answer any questions. People are encouraged to telephone and are assured that no names or ages will be asked.

Bill Blackamore, area youth officer, said the centre is aimed primarily at people under 30 years. However, there is no age limit on the lower end of the scale.

Asked what the answers would be if a young person sought advice on whether to take marijuana or sleep with friends, an official at the centre said no firm line would be taken.

He added: "We shall not say that because society says you must not take pot, you mustn't. We will help callers think through the implications of doing something—ask them if they are just doing it for kicks, doing it through group pressure and so on."

. . . *Truckers*

***The Trucker's Bible (second edition) was published in the summer of this year and has been described by police drug squad members as "the best piece of crime prevention we have seen for some time".**

The book seeks to discourage the "amateur smuggling" of drugs from abroad by stressing the severity of the penalties for so doing.

There are also lists of helpful organizations, advice on a defence against a charge of smuggling, special notes for Americans and Canadians, and details of drug legislation and penalties in different lands. The Trucker's Bible can be obtained from Release, 1 Elgin Ave., London, W93 PR, Tel 01-289-1123. Proceeds from sales of the book go to the agency's "Foreign Bust Fund".

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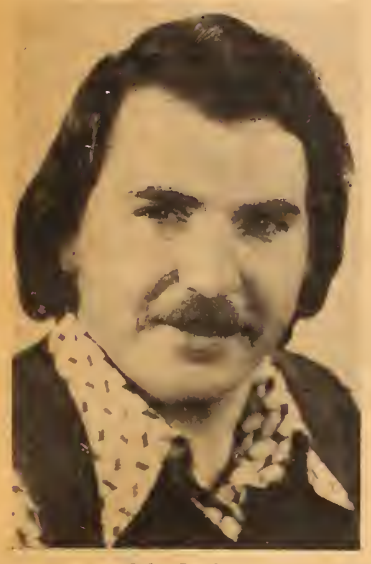

John Devlin

First TC in Cdn. jail

By DOROTHY TRAINOR

MONTREAL—For the first time in Quebec, and possibly in Canada, a therapeutic community drug rehabilitation program has been introduced directly into a federal prison.

It could prove an important move toward changing the lifestyle of the incarcerated drug addict or drug abuser.

The Portage Program for Drug Dependencies (based on the Daytop model) has been conducting milieu therapy sessions for six months at Cowansville Institution, a medium security prison at Cowansville, Que.

The three-hour, once-weekly, sessions are for drug offenders serving lengthy sentences and not currently eligible for parole.

John Welch, special assistant to Solicitor General Warren Allmand, told **The Journal** the solicitor general's office is deeply interested in the project.

It is still too early to say whether it might serve as a model for other federal prisons, he said. "But, we are watching this development very closely".

Provincial authorities also have expressed marked interest in the project.

John Devlin, executive director of the Portage Program, says although the therapeutic community has proved to be a reliable

(See—TC—Page 2)

Cannabis bill

OTTAWA—The special Senate committee hearing on a bill designed to ease the severity of Canada's cannabis laws was scheduled for the last week in January.

The hearings are expected to last about one month, which means the bill could be passed to the House of Commons for final consideration early in March.

The Senate legal and constitutional affairs committee, chaired by Senator Carl Goldenberg, planned to call as witnesses: Health Minister Marc Lalonde; Toronto lawyer Gerald LeDain who headed the lengthy Royal Commission on Non-Medical Use of Drugs; RCMP Commissioner M. J. Nadon; and representatives of the Canadian Association of Chiefs of Police, the Canadian Bar Association and several other interested groups.

Further details on Page 2.

A 'very conservative' estimate

$10 billion in '74: US drug abuse bill

By GARY SEIDLER

SAN FRANCISCO, CAL.—The cost of weeding the United States garden of drug abuse and heroin addiction cost taxpayers more than $10 billion in 1974.

And this $10 billion figure is only a "very conservative estimate" of the real costs of drug abuse in the United States, according to Dr. Robert DuPont, director of the Special Action Office for Drug Abuse Prevention (SAODAP) and the National Institute on Drug Abuse (NIDA).

Perhaps more unsettling is the fact that earlier reports suggesting the U.S. had "turned the corner" in its warlike approach to heroin addiction were premature at best, totally inaccurate at worst.

Speaking at the North American Congress on Alcohol and Drug Problems, Dr. DuPont said of SAODAP's study:

"This social cost study is the first attempt to bring the human tragedy of drug abuse into perspective and to broaden the context for public concern about drug abuse.

"In the past, estimates of these costs have been limited by lack of information in important areas that impact on the total costs of drug abuse."

Dr. DuPont said most previous estimates focused exclusively on the relationship of heroin addiction to property crime.

Still, the new study does not measure the indirect costs of individual, family and community impairment. Also not taken into account are the welfare, insurance and other public health costs.

The study arrived at the $10 billion figure on the following basis:

- $200,000,000 for health costs—drug-related hospital emergency room visits, in-patient care and mental hospital days;
- $1,500 000,000 for productivity costs—absenteeism, unemployment related to drug abuse, loss of earnings;
- $620,000,000 for criminal justice system costs—state and local police salaries, court costs, correctional systems;
- $6,900,000,000 for property loss—income-producing crime to support heroin habits;
- $1,100,000,000 for direct program costs—federal, state, local and private rehabilitation and drug traffic prevention costs.

In recognizing that the measuring of "social cost" is a process rather than an event which occurs at a given point in time, Dr. DuPont said the $10 billion figure is significant in that "it helps us to view the drug abuser in a social context and to understand how his behavior affects our institutions, expenditure of government funds, and the quality of life in our communities.

"Likewise, the social cost estimate serves as a barometer of this country's attempts to grapple with the situation and provides a measure against which we can evaluate the effectiveness of prevention efforts."

The SAODAP disclosure is part of a sober picture painted by DuPont and showing the drug abuse problem apparently worsening in the United States.

"What looked like a continuing national trend of decreasing heroin addiction 18 months ago, has turned out to have been a regional and temporary reduction in heroin use," DuPont remarked.

He cited several recent reports to support the gloomy outlook:

- Analyses of federal treatment program data on incidence in 32 metropolitan areas indicated significant increases in the number of new heroin addicts in 1973. Texas, California and Oregon had to request more federal funds for additional treatment capacity. Illinois, Pennsylvania and Massachusettes, identified by the Drug Enforcement Administration as major Mexican "brown" heroin trafficking centres, report increased demand for treatment.
- In June, 1974, SAODAP dispatched teams to investigate the spread of heroin use in smaller population centres. It was known that heroin use had peaked in some larger cities in 1968-69 but from treatment data, it appeared that

(See—Social—Page 3)

To enhance sex marijuana is 'unparalleled'

By MARY HAGER

SAN FRANCISCO, CAL.—If you have ever wondered about the "real" reason for using marijuana, you need wonder no longer. A team of researchers at the Haight-Ashbury Free Medical Clinic here has an answer.

And you probably knew what it was all the time.

Sex.

A survey of 59 men and 36 women from both the medical clinics and the heroin detoxification unit showed that "insofar as frequent, deliberate use of drugs to enhance sex is concerned, marijuana is non-pareil".

Two of every five people surveyed said they used marijuana at least several times a week, or more often, in conjunction with sex, which led researchers to observe that "for sheer quantitative, everyday importance in the sexual lives of the young, 'hip' San Franciscans sampled in this study, marijuana is quite possibly as significant as all other drugs combined".

Yet, marijuana was not the only drug used for sexual enhancement. Others listed included alcohol, tobacco, heroin, amphetamines, barbiturates and methaqualone.

Some also had used psychedelics to enhance sex, but only occasionally, because of the "heavy" total experience.

Half of the group said they enjoyed sex more while straight than while high, but half also reported the *quality* of their sex life had changed since they began using drugs and for 75% of them, the change was for the better.

Of all the drugs mentioned, cocaine was regarded as the most positive, or sexually potentiating and "there is little question but that, were cocaine as cheap and readily available as marijuana, it would supplant grass as the premium pharmacologic adjunct to the erotic practices of our youthful population," the researchers stated.

Next in ranking for positive effects on sexual functioning were mescaline, LSD and marijuana, with a large gap between these and the next ranked drug, "speed." Alcohol, amylnitrite and PCP were next, with the three "downer" drugs, methaqualone, barbiturates and heroin, at the bottom of the list.

Heroin was placed at the bottom of the list in such areas as one's "chance of achieving orgasm" and the effect on one's

(See—Sexual—Page 5)

Government fights "underground" labs

By BRYNE CARRUTHERS

OTTAWA—Federal drug enforcement officials are fighting a curious, and until now unpublicized, regulatory battle to try and undercut Canada's growing number of sophisticated and inventive underground laboratories specializing in manufacturing new synthetic psychedelics.

In the past, these laboratories have been evading prosecution by keeping a few steps ahead of federal drug regulations: When one psychedelic chemical is uncovered by federal drug enforcement officials and made illegal to possess and manufacture, underground chemists produce a new, closely-related chemical with as much psychedelic effect but not covered by the federal prohibition.

Now, RCMP drug squads are working more closely with federal health department drug officials in trying to turn the tables on the underground labs.

The new approach is aimed at uncovering new psychedelics before they are available on the street, and making them illegal before profits can be made.

At the same time, federal health department chemists are trying to block the manufacture and use of closely-related drugs by making prohibitions more severe.

It's a curious combination of espionage and counter-espionage, combined with a battle of backroom chemists. And with the RCMP's new drug squads specializing in illicit labs, there has been more success for the "feds" and more frustration for the underground chemists.

The latest example of the technique involved the amphetamine variant 2,4,5-trimethoxyamphetamine, which surfaced on the street in Halifax, St. John's, Nfld. and Toronto, during the Christmas-New Year holiday period.

Police heard of the new chemi-

(See—Illicit—Page 2)

Smoking drinking damage heart

By JEAN McCANN

DALLAS—Further evidence that smoking is bad for your heart was presented here at the annual convention of the American Heart Association.

Evidence was also presented that alcohol, even in moderate amounts, damages heart muscle.

The two aspects of heart damage through these addictive habits were presented by Dr. Arthur L. Klatsky of the Kaiser-Permanente Medical Care Program in Oakland, California, and Dr. Leigh Segal, of the University of California at Davis.

Dr. Klatsky described a study of 197 men who were enrolled in the Kaiser-Permanente plan in Oakland, and who dropped dead of heart attacks.

All of these men had previously completed a detailed questionnaire on their ingestion habits. None of them had any history of severe angina pectoris, chronic

(See—Heart—Page 5)

. . . INSIDE THE JOURNAL

New federal drug bill

Police powers may be curtailed

By BRYNE CARRUTHERS

OTTAWA—Under the new federal drug bill before the Senate, the current almost limitless police powers of search for illicit drugs would be curtailed substantially.

And when the drug bill is passed, probably later this year following special Senate Committee hearings and then Commons consideration, police could find themselves in civil law courts being sued for searching individuals for drugs without "reasonable" grounds for suspecting the individuals had illicit drugs in their possession.

Hidden in the legal verbiage of the bill to change sections of the Food and Drugs Act and the Narcotics Control Act (along with relevant sections of the Criminal Code which covers both acts), is a small but important change in wording on police powers of public or private search of individuals for drugs.

Federal lawmakers would restrict police officers to searching only persons they "reasonably" suspect to have in their "personal possession" an illicit drug such as cannabis, heroin, or restricted and controlled psychedelics covered by the Food and Drugs Act or the Narcotics Control Act.

The change, say federal officials, was designed to prevent a repeat of the infamous Fort Erie drug raid last year, in which local police subjected dozens of customers in a Niagara peninsula bar to searches for drugs. Some of the women were subjected to intimate body searches for hidden drugs.

Subsequently, a public enquiry was held on the necessity and appropriateness of such a sweeping drug search, especially as the raid had been thwarted when police agents were spotted in the bar just before the raid.

Only a small quantity of drugs was uncovered by the raid. Under current drug laws, police can search anyone in such raids, whether or not there is reasonable suspicion the individuals might possess illicit drugs.

And as victims of the Fort Erie raid have discovered, little can be done under current drug laws, against unreasonable drug searches.

But that will all change under the proposed drug law changes.

Federal officials explain that police would be able to search only people a police officer "reasonably" suspects to have in his personal possession a "controlled drug" (as in the case of cannabis and other hallucinogens that would be covered by a modified Food and Drugs Act) or a "narcotic" (as covered by the Narcotics Control Act, including heroin).

A private citizen who believes he was subjected to a search not based on such reasonable suspicions could launch a civil suit against the police officer, who would then have to "show cause" for the search.

Federal officials claim the change is designed to protect the civil rights of Canadians against unreasonable drug searches.

But they admit it will not be "foolproof" and prevent all unnecessary drug searches and "hassling".

On the other hand, should some policemen face civil suits alleging unreasonable searches, police would undoubtedly think twice about large-scale drug raids of public (and private) places.

Even as federal officials express concern for protecting civil rights, other changes to the two acts would still seem to violate individual civil rights.

One example is the change that would require people charged with possession of a controlled drug (such as cannabis) or a narcotic (such as heroin) for the purposes of trafficking (a more serious offence than simple possession) to prove they are not, in fact, possessing the drug with the intent of trafficking.

Under the proposed drug changes, people charged with possession for purposes of trafficking would, in effect, be put on trial for two separate crimes.

First, if the accused pleaded not guilty to the original charge, the trial would focus on the crime of simple possession.

If it was not shown that the individual was in possession of the illicit drug, then the original possession for the purposes of trafficking charge would be dropped and the individual found not guilty.

But, if it was decided the individual was in possession of the drug, then the accused would be given an opportunity to "adduce evidence", i.e. prove, it was simple possession, not possession for the purposes of trafficking. The Crown prosecutor would try to refute the evidence.

If the accused could not convince the court the drug was for personal use, the individual would be convicted of the more serious charge of possession for purposes of trafficking.

If the accused successfully convinced the court it was simple possession, then the possession for trafficking charge would be dropped.

But the accused would then be found guilty of simple possession.

Cannabis offences

Changes across the board

By PETER MICHAELSON

OTTAWA—The Senate cannabis bill proposes to change the existing penalties for five categories of cannabis offences, reducing maximum penalties for all but one.

The bill would also allow prosecutors to proceed by way of the less serious summary conviction for all offences. Under existing penalties there is provision for summary conviction only on possession charges.

The new laws would also prevent courts from prosecuting possession charges by way of the more-serious indictment.

Cultivation is the only offence with a longer maximum jail term under the new laws, an anomaly which federal officials justify by saying severe maximum penalties are needed for organized criminals.

Simple possession

Under proposed penalties, a first offence would be liable for a fine of up to $500 or imprisonment for up to three months in default. A subsequent offence could draw a fine of up to $1,000 or imprisonment for up to six months in default.

Existing penalties on summary conviction call for a fine of up to $1,000 or imprisonment for six months or both on a first offence, while setting a maximum fine of $2,000 or imprisonment for one year or both on subsequent offences.

The proposed penalties prevent courts from proceeding by way of indictment but the existing laws set a maximum seven-year term for indictable conviction.

The majority recommendations of the LeDain cannabis report recommended no prohibition against possession.

Trafficking

A summary conviction under the proposed penalties calls for a fine of up to $1,000 or imprisonment for up to 18 months or both. There is no provision for summary conviction under existing laws.

Indictable offences under the proposed laws call for a maximum 10-year sentence while existing laws could send offenders to jail for life.

The LeDain majority report recommended a maximum penalty of 18 months for summary conviction, with a fine in lieu of imprisonment. On indictment, the report recommended a maximum of five-years imprisonment and, again, a fine in lieu of imprisonment.

Possession for the purpose of trafficking

Proposed and existing penalties are the same as for trafficking. The LeDain commission also made the same recommendations it had for trafficking, but said the accused should not be charged if he can raise a reasonable doubt as to his intention to traffic.

Importing or exporting

The proposed laws call for imprisonment for up to two years on summary conviction, while existing laws have no provision for the courts to proceed by way of summary conviction.

By way of indictment, the proposed laws call for imprisonment up to 14 years and not less than three years. However, the three-year minimum would not apply where the convicted person can prove he imported or exported for his own consumption only.

Existing laws call for a maximum sentence of life imprisonment and a minimum of seven years.

The LeDain majority recommended that importing and exporting be included in the definition of trafficking but subject to higher maximum penalties.

Cultivation

Summary conviction under proposed laws calls for a fine of up to $1,000 or imprisonment for 18 months or both. Again, existing laws have no provision for summary conviction.

A 10-year jail term is possible under the proposed laws for indictable offences, compared with a maximum seven-year imprisonment under existing laws.

The LeDain commission recommended cultivation not be a punishable offence unless done for trafficking. If done for the purpose of trafficking, it should carry the same penalties as trafficking.

Illicit laboratories

(Continued from page 1)

cal just before it was detected on the streets. And regulatory wheels were put in motion immediately to make the new chemical variant illegal, under Section H of the Food and Drugs Act.

Such a prohibition provides police with a basis for laying drug charges against operators of such laboratories, should the labs be uncovered. Without the prohibition, the federal government would have to try and charge the underground labs on a host of lesser charges, such as operating a drug manufacturing business without properly notifying the federal government, or producing drugs not pre-cleared by Ottawa.

Just as important, the prohibition quickly makes use of the new chemical unpopular—or so the theory goes—thus minimizing its use and the profits made from its manufacture underground.

The new regulatory prohibitions came into effect within days of Maritime federal chemists' identification of the new chemical.

The federal government publicly announced, on Jan. 3, the presence in Canada of the new drug, which it described as being "very dangerous". It also said the 2,4,5-trimethoxyamphetamine, which had been offered for sale as a yellow or beige powder sometimes containing dark specks and in capsule form as well, might be offered for sale as PMA, MDA or other hallucinogenic drugs.

Curiously enough, it never announced that the new drug had quickly and quietly been added to the restricted schedule H of the Food and Drugs Act.

Not so strangely, the prohibition not only covered 2,4,5-trimethoxyamphtamine, but also covered all of the chemical's salts and isomers. This broader prohibition should block underground labs from simply switching to a close chemical relative of the new psychedelic as they have done so often and so quickly with other banned hallucinogens in the past.

The first example of this regulatory warfare against underground laboratories occurred almost three years ago when federal drug enforcement officials uncovered a new drug on the streets of Toronto that was called Harmaline. The drug and its relative, Harmalol, was put on the restricted list of the Food and Drugs Act.

Similarly, when MDA (another amphetamine drug) was first discovered, the federal government quickly banned it and its relative MMDA. The same occurred with PMA.

More recently, when one sample of dimethoxyamphetamine was found on the streets, it and four related compounds were made illegal.

The reaction time on 2,4,5-trimethoxyamohetamine was vastly improved compared to problems experienced in warning the public about Haramline and then making it illegal.

The ideal is to uncover the new illegal drugs before they are on the streets, make them illegal, and preferably raid the underground labs before they can get their new, and now illegal, drug on the market.

TC for Canadian prison

(Continued from page 1)

change-agent in drug dependencies, the same concept introduced into the prison setting must still be considered experimental.

Deprivation of liberty creates its own set of special problems and the question is whether the concept that has served well on the 'outside' can break through even more complicated ego-defences with prison walls.

Devlin told **The Journal** he is optimistic, noting that the backgrounds of the Cowansville prison population in therapy are almost identical to those of the population at the Portage residence, at Lake Echo, Que.

"One sees the same childhood fixations, negative self-image, low frustration tolerance, social rejection and aggressiveness. In terms of behavior, both groups are deviant. In many instances, the only difference is that the prisoner got caught."

The Portage Program has also become involved in other correctional areas.

An association with the criminal justice system began with the setting up of a Court Diversion Program. Portage now maintains an office at the Palais de Justice in Montreal and its staff works closely with judges and probation and parole officers regarding drug treatment referrals.

In this way, drug users facing sentences not yet served can be diverted—at the discretion of the judge—to the Portage Program.

"The referrals we propose, however, are not just to the Portage Program," Devlin said, "but to other rehabilitation settings as well—depending upon the need of a specific model.

"More recently, Portage has been designated as a community-based residential treatment centre by Canada's Solicitor General, thereby making our program eligible to take parolees into treatment. This means prisoners can be paroled directly to Portage for rehabilitation."

In all, Devlin said, more than 30% of Portage residents come through such legal channels. The remainder come through various referrals or voluntarily.

With the approval of the Solicitor General, psychologist Louise Nadeau, assistant director of treatment at Portage, is conducting an eight-week training workshop at a federal staff training centre near St. Vincent de Paul Penitentiary. The program, which introduces prison personnel to concepts of milieu therapy, was established on the suggestion of the Portage group that this type of therapy could work within the prison setting.

According to Devlin: "The guards and correctional officers who are being trained under Louise Nadeau are getting excited about the possibilities of more interaction with the prisoners.

"They have gone out of their way to visit us at Lake Echo. They don't want just to be guards—they want to help. Above all, they would like to see some rehabilitative results from their work.

"The provincial Ministry of Justice is also very interested in these areas of our work," said Mr. Devlin.

Women swelling AA ranks

SAN FRANCISCO, CAL.—Women are gaining a dubious equality in the once male-dominated world of Alcoholics Anonymous.

Women account for nearly one in three (31%) of new members of Alcoholics Anonymous in the last three years, and more than one quarter of AA's total membership.

These facts were revealed in a survey of 13,467 AA members in the United States and Canada, the largest-ever survey of recovered alcoholics.

Dr. John L. Norris, AA board chairman, told a press conference at the North American Congress on Alcohol and Drug Problems that drinking no longer is regarded as purely a man's domain and that women are less inclined to hide their drinking.

"When I was coming up, the acceptable social drink for women was tea," said Dr. Norris. "Now, it's cocktails."

Women now make up 28% of the group's membership compared to 22% in 1968 and 26% in 1971. The survey was designed to provide a profile of Alcoholics Anonymous and is conducted every three years among AA groups in North America.

By GARY SEIDLER

The latest survey also showed that one in four members of AA at a typical meeting has not had a drink for five or more years; 91% of these, each succeeding year, will enjoy continued sobriety and will continue to attend AA meetings regularly.

Over the last six years, the percentage of young people in AA shows no increase, Dr. Norris reported. The 1974 survey puts 7% in the under-30 years bracket, 55% between 30 and 49 and 37% at 50 or older.

Thirty-eight percent of the membership polled, identified themselves in the executive-professional-technical category. Another 32% were identified as clerical or blue-collar workers and 11% as housewives.

Counselling agencies are mentioned more often as a primary factor in coming to AA by those entering in the last three years. There is a corresponding decline in the citing of "another AA member" as a prime factor, although this remains the single reason most often named.

In a separate survey, questionnaires were distributed to some 1,000 U.S. and Canadian corrections institutions which have functioning AA groups.

An inmate's chances of "making it on the outside" are improved by participation in AA, according to 96% of the responding administrators. Further, 90% regarded AA as "contributing to the objectives of the institution".

Alcoholics Anonymous operates chiefly through more than 22,000 local AA groups meeting in 92 countries. There are nearly 13,000 such groups in the U.S. and over 2,100 in Canada. Estimated worldwide membership stands at 800,000.

'Physicians in 'alcoholic haze'

By MARY HAGER

SAN FRANCISCO, CAL.—The alcoholic patient often becomes the physician's "whipping boy," an attitude reflected in the way many physicians treat, or refuse to treat, alcoholic patients, a North Carolina psychiatrist suggested here recently.

Dr. John A. Ewing, director of the University of North Carolina's Center for Alcohol Studies, observed that many physicians have a great deal of trouble dealing with their own feelings about alcohol and alcoholism.

To the physician, alcoholism implies a lack of control, and control is extremely important to the physician who must exercise a great deal of it, first to become a physician, and then to practice, Dr. Ewing told members of the American Medical Association for Alcoholism.

During training, the physician has had to work hard, postponing his rewards. When he does get to enjoy his rewards, "the contrast between the long hours of responsible decision-making with their emotional demands is counterbalanced by the rewards of relaxation, often accompanied by an alcoholic haze," he continued.

Dr. Ewing contended physicians rarely admit to being drunk or to having a problem with alcohol.

They feel, he said, that alcoholics are always from a different social class or have different backgrounds and belong on skid row and that, somehow, there is a barrier between "normal drinkers" and "alcoholics".

Yet, far more drinking goes on among physicians than among the general population, he said. And physicians do not recognize problems they have with alcoholism because they view alcoholics as weak and self-indulgent and see themselves as strong and self-controlled, he said.

This, he suggested, is one reason why they may have trouble dealing with alcoholic patients. Physicians cannot imagine such self-indulgent tendencies in themselves and tend to "vent my rage upon anyone who gives in like this," he explained.

The physician's own problems dealing with alcoholism are far more important than other reasons given for their rejection of alcoholic patients, he said.

For instance, if it were true that physicians avoid long-term cases and only like fast results, "we would all be hearing about poor diabetic patients who cannot get anyone to take them on for treatment".

The idea that physicians don't learn about alcoholism in training because they only get a bit here and there doesn't make sense, he said. Diabetes, for example, is taught in many different departments and from many viewpoints, yet the medical student is able to synthesize the information.

Dr. Ewing suggested the physician who openly refuses to treat the alcoholic patient probably does less harm than the physician who is not aware of his attitudes.

The doctor who refuses invariably refers the patient to someone who will treat while the unaware physician "may hospitalize unnecessarily, prescribe excessively, and perhaps create an iatrogenic dependence on drugs other than alcohol".

Social cost estimate

(Continued from Page 1)

heroin use might be spreading to smaller cities.

- Nationally, and in every region of the U.S., hospital emergency room treatment for heroin overdose has increased dramatically every quarter since September, 1973. Specifically, the period July-September, 1974 has shown an overall increase of 66% above the July-September, 1973 quarterly level.
- Thirteen million Americans are estimated to be regular users of marijuana, with 2½ million estimated daily users. In one high school, where complete data exists, the number of freshmen using the drug doubled to 50% between 1968 and 1974. (Recently, new evidence has been presented indicating potentially significant medical problems which may be encountered from long-term or moderate-to-heavy use of marijuana).
- A recent report from a nationwide survey of 78 schools in 10 cities for the school year 1973-74 indicates more than one-third had used synthetic drugs non-medically and, of these, 24% had used barbiturates and 22% had used amphetamines. An estimated 30% of those in federally-funded treatment programs are being treated for non-opiate problems.

During a press conference, DuPont conceded the Federal government had previously thought of the drug abuse problem as a war which could be won given sufficient troops and armament.

But with the growing realization that the problem is constant, he drew the analogy of weeding a garden.

"If you keep at it all the time there are major benefits."

Referring to the 1973 statement that "the corner had been turned" with respect to increasing heroin addiction, DuPont later told reporters the major source for this optimistic statement had related to a decline in incidence of hepatitis.

Between 1969 and 1972, the incidence of hepatitis as related to intravenous drug use increased from 19,500 in 1969 to 36,000 in 1972.

In 1973, this figure dropped to 29,000, according to a well-established national reporting system.

He explained that in 1969, the problem was primarily concentrated on the east and west coasts of the U.S., essentially in New York and in California.

In the following years, heroin use began spreading throughout the country, to middle America, at a more uniform rate.

This served to counteract the relative reduction, or at least stability, of heroin use in the high concentration areas.

DuPont further explained that while there was a significant reduction in heroin coming into the country when the Turkish Government banned poppy cultivation in 1971, importation of the drug from Mexico has now been firmly established.

"The replacement of the Turkish-Marseilles route with heroin from Mexico is one of the primary factors in the (current) deterioration," DuPont said.

Joan Curlee-Salisbury

Donald Goodwin

...In memory of Jellinek

SAN FRANCISCO, CAL.—A clinical psychologist and a psychiatrist are the first United States recipients of the E. M. Jellinek Memorial Award for outstanding contribution to the study of alcohol problems.

Dr. Joan Curlee-Salisbury, a psychologist at Veterans Administration Hospital, Indianapolis, and Dr. Donald Goodwin, a psychiatrist at Washington University, St. Louis, received the international award at the opening here of the North American Congress on Alcohol and Drug Problems, Dec. 12-18.

Presentation of the awards—bronze castings of the head of E. M. Jellinek and a cash prize—were made by Archer Tongue, executive director of the International Council on Alcohol and Addictions and president of the E. M. Jellinek Memorial Fund, and Mark Keller, editor of the Quarterly Journal of Studies on Alcohol, Rutgers School for Alcohol Studies.

The fund was established in 1963 following the death of Dr. Jellinek, regarded as the dean of research scientists in the field of alcoholism.

Dr. Jellinek was introduced to the problems of alcoholism in 1939. "He was the greatest scholar who came to work in this field and many who knew him during the next 25 years thought him a genius," Mark Keller told an audience of approximately 2,000 attending the Congress.

"He quickly became the fountainhead of knowledge and thinking about alcohol problems. But he also turned out to be a creative activist. He was an originator, a moving spirit, an inspirer of all the activities and events and organizations that culminated in this very congress," Mr. Keller continued.

The 1974 award winners were determined by a U.S. selection committee.

Dr. Curlee-Salisbury, the first woman to receive the award, has been interested in alcoholism problems since the beginning of her graduate academic career.

Her dissertation for her PhD in psychology at the University of Minnesota in 1968, dealt with a comparison of men and women alcoholics.

She later turned her attention to problems of treatment of alcoholism, particularly problems of attitudes, and to combined Alcoholics Anonymous and psychotherapy. She subsequently studied blackouts and depression, and most recently a phenomenon of fear of heights among alcoholics.

Dr. Goodwin's interest in alcoholism began with clinical trials of drugs having a disulfiram-like action. He has also studied theoretical aspects of alcoholism and the action of alcohol, especially in relation to memory, blackouts, and state-dependent learning.

He was the leader of an international team of researchers who investigated the life histories of a group of adoptees of alcoholic fathers who were raised by non-alcoholic adoptive parents. This study provided new hints of a possible genetic factor in the development of alcoholism.

Previous Jellinek Memorial Award winners were: Dr. Jena-Pierre Von Wartburg, a Swiss enzymologist (1968); Dr. Kettil Bruun, a Finnish sociologist (1970); Dr. Harold Kalant, a physiologist, and Mr. Robert Popham, an anthropologist, both with the Addiction Research Foundation of Ontario, Canada (1972).

Presidential candidate seeks greater federal effort

GEORGIA GOVERNOR Jimmy Carter, a declared candidate for the 1976 Democratic Presidential nomination, has called for greatly expanded federal efforts in the fight against alcoholism.

"Alcoholism is our greatest drug problem," he said. Yet "we have failed at the national level to give it the priority and the resources it deserves."

He said the United States has about 9 million alcoholics and another three million problem drinkers. Between 40% and 50% of convicted felons have a history of alcoholism and more than half of those arrested for criminal homicides were drinking heavily prior to killing, he said.

Gov. Carter emphasized the need for a single federal alcohol/drug abuse agency, noting that 30 states have already consolidated their alcoholism and drug abuse agencies but at the federal level such agencies remain separate and "largely uncoordinated".

"There is no clear definition at the national level of what our goals are in dealing with alcoholism. There is no clear concept of what a model, national program should be."

He cited increasing duplication and overlap at the federal level as a hindrance to progress, and charged that recent administrations have ignored research on the problem.

"There is a desperate need for sufficient funds to encourage additional research and the willingness to use that research in designing treatment programs."

He said Georgia has made great progress in prevention and treatment of alcoholism, using existing personnel and resources. And he attributed this progress to Georgia's establishing a single agency to coordinate drug programs.

Harvest method curbs diversion

By DAVID ZIMMERMAN

WASHINGTON—Swallowing their disappointment at Turkey's return to poppy culture, US drug officials say they are relatively pleased by the Turks' announcement they will switch to a method of harvesting poppies that allows less opportunity for diversion of the material into illegal channels.

The Turks say from now on they will use the poppy straw method of harvesting, rather than their traditional technique of lancing the capsules and scraping the opium gum from their outsides.

"We have indicated we are pleased with this decision," said Ms. Candace Cowan, chief of international affairs for SAODAP.

"The decision the Turkish government made (to restore opium poppy culture) was very disappointing to us. But we're hoping they will police it very tightly, and we're hoping this (poppy straw harvest method) will help them in that."

The difference between lancing and poppy straw extraction, and the reasons the latter is considered less dangerous, were explained recently in **The Journal**, (September, 1974) by Mr. Donald Fishler, an international programs officer at the US Department of Agriculture, Beltsville, Md.

In lancing, Fishler said, the farmer—usually assisted by the rest of his family, since the procedure requires considerable labor—goes into the fields after the petals have fallen from the flowers and the seed capsules are ripening. He uses a sharp instrument to cut holes or gashes in the sides of the capsule.

Overnight, the sap oozes through the cuts, and collects and hardens on the outside of the capsule as latex, or gum. The farmer returns the next day to scrape the gum from the outside of the capsule.

The gum can be easily processed into heroin, and thus the farmer may be tempted to sell some, or all, of his harvest to illegal traders.

In harvesting what is called "poppy straw", the farmer simply cuts off the top of the plant—capsule, leaves and stem. He then dries it and sells it.

The straw, unlike the latex, is very difficult to process, Fishler explained. A major industrial process is required that he said is outside the capabilities of illicit operators. For that reason, harvest of poppy straw, particularly if accompanied by a ban on lancing poppy capsules in the field, can limit illegal diversion.

The criticism has been raised, Fishler added, that the farmer might cut his poppy crop, and, once he had it safely in his shed, harvest some of the gum by lancing.

This criticism is uninformed, the agricultural expert said, because a lanced capsule will only bleed if it is still attached to a living plant, for it is capillary pressure in the growing stem that carries the sap up into the capsule and through the wound in its wall.

The Turkish government, according to Ms. Cowan, has said it will buy all the farmers' poppy straw, and sell the unprocessed straw to countries that can process it to extract the morphine and thebane for the manufacture of codeine and other analgesics. The Turkish government, she said, may also build its own poppy straw processing plant.

Turkish opium poppies - U.S. bound?

U.S. faces codeine shortage

WASHINGTON—A drastic change in stance—from world poppy policemen to poppy growers—may be forced on the United States by a codeine shortage.

For 1975, officials expect to deal with the problem by temporarily lifting the ban on the importation of poppy straw extract.

This would help both to bolster sagging supplies of poppy gum and to prevent depletion of the US stockpiles of opium.

For the long term, however, the US may have to consider permitting domestic growth of poppies, notably the species bracteatum.

The prospect was broached as a possible long-term solution in a White House memo authored by Ed Johnson, chairman of the Opium Task Force, and leaked to the press.

Johnson, also special assistant to the deputy director for Federal Drug Management of the Office of Management and Budget, admits touching on domestic growth as one solution but plays down the likelihood that it will come about.

Not only does it require three years to establish a crop of the perennial bracteatum but also US policy is to discourage countries from growing poppies, the ultimate goal being to eliminate their growth.

It may be easier to be persuasive, Johnson reasons, if the US refrains from growing the poppies. Even if bracteatum proves to be a good source, foreign countries may be encouraged to grow it instead, he says.

Bracteatum may be grown now in the US but only for ornamental purposes. One problem, says Quentin Jones, staff scientist for the US Department of Agriculture, is that seed is not readily available.

That there is an increasingly serious shortage in the US of pain-killing drugs derived from opium was charged in a signed editorial in the Dec. 26 New England Journal of Medicine.

(Codeine, the major medicinal drug derived indirectly from opium, accounts for about 90% of the medicinal opium used in the United States, says the editorial.)

In any major epidemic or other national emergency, a shortage could cause great suffering, it says.

Last year, Congress authorized release of more than 200 tons of opium from the Federal strategic materials stockpile to meet civilian needs. That release cut the stockpile by more than half.

The present stockpile, said the editorial, would be "grossly inadequate" for a national emergency.

The editorial was signed by Dr Leonard Greentree, a physician in Columbus, Ohio. While signed editorials do not necessarily express the opinions of the editors of the highly respected journal, they do represent points of view to which the journal is sympathetic.

"There is obviously only one long-term solution to the present medicinal opium crisis in the United States. The United States must become self-sufficient in opium. . . . must plant, cultivate and harvest, the opium poppy for its own use." wrote Dr Greentree.

The physician has been concerned about consequences of medicine shortages since the late 1930s when he was caught up in the exodus from Nanking after the Japanese captured that Chinese city. He and many companions trying to reach Shanghai had dysentery and could obtain no medicine.

"I would have given everything I had for some medicine then," he recalled.

The mild properties of the red-flowered bracteatum which grows wild in Iran, were discovered about two years ago and the poppy is now being grown successfully in Norway, Iran, Turkey, and Beltsville, Maryland. Several US pharmaceutical companies are also experimenting with its growth.

However, among other things, scientists want to know whether the poppy yields any undesirable drugs.

For the moment, one advantage is that bracteatum yields thebaine, unlike the poppy Papaver somniferum which yields morphine which, in turn, is the source of heroin.

Bracteatum also requires fewer acres to produce larger yields. And, the latex must be extracted chemically as it is too thin to collect manually.

Low tar cigarettes "lesser of two evils"

FLORENCE, ITALY—Cigarette smokers who have smoked low tar (filter) cigarettes for 10 years or more have a significantly lower risk of lung cancer than those who continue to smoke non-filter cigarettes.

This is true even though the non-filter user is smoking a cigarette lower in tar than the ones produced 20 years ago, according to Dr Ernst Wynder of the American Health Foundation, New York.

He told the XIth International Cancer Congress here that studies have shown that patients with lung cancer now started smoking with cigarettes in vogue in the 1940s and early 1950s.

So, "we may assume that those who began their smoking careers with the new low tar cigarettes will have lower lung cancer risks than the smokers of 20 years ago."

Dr. E. Cuyler Hammond, vice-president, department of epidemiology and statistics, American Cancer Society, reported on studies of the interaction of cigarette smoking on asbestos workers in Canada and America.

He said when occupational exposure to asbestos was found to increase the risk of lung cancer, the question arose as to whether it acted alone or in combination with some other agents. Cigarette smoking is by far the most common agent associated with increased death rates from the disease.

By 'multiplicity of inputs'

Alcoholism 'obscured'

By ASA ZATZ

ALCOHOLISM IS one disease in one world but that central fact is being obscured, says Dr Frank A Seixas, medical director, National Council on Alcoholism, New York.

The underlying facts of alcoholism "vary little between rich and poor, social environments, cultures, or nations", Dr. Seixas told the Second International Congress of the Rehabilitation Medicine Association.

However, great confusion exists because of the "multiplicity of inputs"—legal, psychological, sociological, anthropological, medical—that modify the circumstances in individual cases, he said.

To lighten the conceptual burden, Dr. Seixas outlined criteria he believed might clarify the situation.

The criteria, crystallizing expert opinion on diagnosing alcoholism, were:

—Alcoholism is a subacute brain syndrome to be distinguished from the acute form that arises from casual drinking and chronic, permanent syndrome, such as Korsakoff's psychosis.

—Development of tolerance is necessary to achieve high blood levels of alcohol over long periods of time. High levels over a long period have now been observed to underly most of the physical consequences of alcohol. Studies in experimental cirrhosis in baboons, for example, have demonstrated the disease is not produced until at least 50% of total caloric intake is made up of alcohol. This links together late physical effects and other known underlying attributes of alcoholism.

—It is essential to make the diagnosis of the psychiatric background of the patient when he is alcohol-free in order to determine whether or not drug treatment, such as lithium for manic-depressive conditions, is called for.

—According to the latest figures, while death from heart disease has decreased 15%, mortality from cirrhosis of the liver has risen 67%, with highest increments among the non-white population. On the other hand the number of new groups formed in Alcoholics Anonymous in the United States has climbed steadily in recent years. After remaining stable from 1960 to 1969, there has been a steady yearly rise.

The Hughes-Javits Bill, passed in 1968, stimulated money-flow into identification, treatment, and referral to Alcoholics Anonymous and other modalities. These treated people not only provide a model of the probabilities of enjoying life without alcohol but also directly assist other alcoholics to treatment.

The positive conclusion is that if a critical mass of recovered alcoholics were to be obtained, there might be a natural feedback that would tend to reduce the gravest aspects of the problem of alcoholism, said Dr. Seixas.

Cape Breton's 'blueprint for planning'

From 'local effort' to model program

Marvin Burke

By MILAN KORCOK

CAPE BRETON, N.S.—The use of local initiative to combat drug dependency programs in discreet geographical areas has remained a principle easier to talk about than achieve in many areas.

But, in the Cape Breton region of Nova Scotia, not only has this mobilization of local effort resulted in a model program, it has yielded something of a blueprint for drug planning in the rest of the province and, very possibly, for other parts of Canada.

The core of the demonstration program, the Cape Breton Addiction Centre, which functions under the aegis of the Nova Scotia Commission on Drug Dependency, has in recent months undergone intensive evaluation by drug program planners from several other provinces, and groups from federal government.

Reports from all of these evaluators show strong support for the way local groups, acting through regional planning boards, can function effectively.

The Cape Breton program includes a detoxification unit, an outpatient department, a short-term therapy program, a ward for homeless male alcoholics at the Cape Breton County Mental Hospital, a half way house, and a long-term rehabilitation facility. Supplementing these facilities is a program emphasizing community participation in drug treatment.

As one of the evaluators noted: "This (emphasis) should eventually facilitate more direct involvement of non-professional people in treatment, at considerable relief to the Nova Scotia taxpayer."

Under the Nova Scotia plan, funding comes from the provincial commission to regional boards for all programs.

The current organization of the commission calls for its work to be carried out through local committees and regional boards. There are five regions and one regional board planned for each of these. Within each region there may be many local committees which are the actual action groups.

When the Drug Dependency Commission was formed, it provided small amounts of seed money to various communities to help them develop programs.

The local committee in Cape Breton, however, was not satisfied with what the commission offered and about 15,000 people signed a petition to the provincial government asking for adequate services to be set up in Cape Breton.

As a result, the demonstration project was established and this region now has the best developed services in the province.

Much of the emphasis in developing this network has been on involving professional and volunteer civil groups already in existence.

Marvin Burke, executive director of the Commission on Drug Dependency, indicates certain priorities for further development of the Cape Breton program and implementation of similar efforts elsewhere:

- Increased integration for existing services
- Increased involvement of the medical profession
- Expansion of the industrial programs
- Increase education programs
- Implementation of a documentation, evaluation and research program.

Drug dependency in the Cape Breton region has been of growing concern to the local community. Union and management officials at Sydney Steel estimate alcohol dependency among their workforce of 3,500 to be as high as 10%.

Another high risk group can be found within the native Canadian communities. Indian spokesmen have been concerned about dependency among their people for some time. Inhabitants of geographically remote areas are seen as another target population.

Heart damage and alcohol

(Continued from page 1)

congestive heart failure, or other medical conditions.

"What we did in this part of our study", Dr. Klatsky told **The Journal**, "was to try to find out what predictive factors there might be for sudden cardiac death."

Dr. Klatsky said the study showed no correlation between consumption of alcohol and sudden cardiac death, although a correlation had previously been shown between heavy drinking and myocardial infarction.

Questions on coffee drinking and aspirin use did not indicate these were either risk factors or favorable factors (as with aspirin, by thinning the blood).

Data on cigarette smoking, however, bore some fruit. In the sudden death cases there was an especially high correlation among sudden death and young heart victims who smoked.

However, "the proportion of smokers was similar for those who suffered instantaneous death to the proportion for those who had a longer duration of symptoms before dying. This suggests that cigarette smoking does not provoke sudden cardiac death primarily by provoking fatal arrhythmias, but rather that the effect of smoking acts either on the underlying atherosclerotic process, or on factors precipitating acute myocardial infarction."

In her presentation, Dr. Segal described studies she made to determine "the fundamental causative role of ethanol (alcohol) in the pathogenesis of myocardial damage.

"The possiblity that alcohol may exert a direct toxic action on heart muscle has been suggested by the increased prevalence of cardiomyopathy in patients with a history of chronic excessive ethanol ingestion."

To test the hypothesis that alcohol exerts a direct effect on the heart muscle, Dr. Segal studied male rats given either a 5%, 10% or 25% solution of ethanol for periods ranging from 25 to 45 weeks. The percentage of daily calories consumed as ethanol varied from 9.5% in one group to 32% in another.

However, all the animals received the standard requirements of vitamins in their food, which may not parallel the state of some human drinkers.

Dr. Segal next studied the condition of the myocardium of the rats under an electron microscope. Even after only seven weeks, in the group consuming the 5% ethanol, amounting to 9.5% of their daily calories, Dr. Segal found a number of ultrastructural abnormalities.

"All of the alterations noted in the group which consumed 5% ethanol were more prominent and numerous in the animals who consumed 10% and 25% ethanol," she said. In the animals consuming the most ethanol, there were additional abnormalities.

While animal data cannot be directedly extrapolated to humans, Dr. Segal noted, the animals in the 10% ethanol group "might be compared to a person taking a couple of cocktails a night.

"Also, none of our animals—even on the highest ethanol diets—would be comparable to an adult human on skid row, most of whose diet consists of alcohol. So our animals were really receiving low to moderate amounts of alcohol.

"In the animals consuming 10% ethanol we found, as early as seven weeks on that kind of diet, that there were abnormalities in the ultrastructure of the heart, but we did not at any time see any muscle dysfunction.

"However, at the higher levels, in addition to the ultrastructure damage, we saw the beginnings of muscle dysfunction, which took the form of a shorter time to peak tension of the papillary muscles. This would be indicative of a shorter duration of the active state of the muscle, dysfunction in the isolated mitochondria, and in the ATPase activity of the isolated myofibrils.

"I think that someone who regularly drinks alcohol should re-evaluate what he's doing, after seeing the body of evidence that ethanol, or one of its metabolites after it's been consumed, is causing cardiac damage."

Sexual enhancement with marijuana

(Continued from page 1)

sexual desire. The "downers", as a group, had a poor reputation in all areas of sexual functioning, despite the fact that downers have traditionally been considered sexual enhancers.

However, the study continued, "our subject group was fairly well experienced sexually and very liberal in their attitudes" leading to the speculation that "the capacity of 'downer' drugs to disinhibit one's sexual behavior—i.e. to weaken the inhibitive effect of moral restraint, social fears, or physical distaste—is fairly inoperative as far as our respondents are concerned.

"With a more uptight, sexually inhibited group of Americans, the importance of 'downers'—and alcohol—in encouraging sexual acting-out would be much greater."

A common view of alcohol in the study was that "alcohol makes for sloppy sex" and barbiturate users were regarded as "without class".

When respondents were asked to choose between the drug of their choice and sex with anyone of their choice, three of four favored sexual contact. Of those who selected a drug, most chose heroin or cocaine.

This finding "that *anyone* would choose a drug in this situation would surprise many young Americans brought up to regard sex as the essence of one's fantasy life," the study noted.

For two of five in the survey, sexual contacts were usually related to drug-using situations. However, a similar number said their sexual contacts were rarely related to drug use.

The respondents judged alcohol, cocaine, heroin and the psychedelics as relatively equal in their aphrodesiac or "seducing" capacity—i.e. making one "more likely to have sex with a partner whom I would not be attracted to while straight", but heroin was poorly regarded as far as control over erection and orgasm was concerned.

Heroin was also most commonly linked with "losing interest in sex" followed by speed, barbiturates, psychedelics and alcohol.

The study noted that heroin and alcohol were described both as sexual stimulants and as depressants, and suggested that the difference for alcohol is dose-related but for heroin is not as easy to explain.

Dr. George R. Gay, director of clinical activities, and John A. Newmeyer, epidemiologist at the clinic, who conducted the survey with research associates Richard A. Elion and Steven Wieder, concluded that the survey demonstrated "we certainly are now dealing with an experienced and sophisticated drug/sex wise young population."

Drs. Gay and Newmeyer also evaluated the differences between addicts and non-addicts in regard to drugs and sexuality and the differences between homosexuals and heterosexuals in the survey.

They found that addicts had higher ratings for the ways in which various drugs enhanced sexual performance than non-addicts. This was "surprising, in that we would expect the junkie group to be more drug-experienced, and hence more 'jaded' and less susceptible to whatever sexually-enhancing qualities may be intrinsic in various drugs."

The addicts in the survey generally felt drugs enhanced sexual performance while the non-addict group found drugs more important in the areas of touching and the ability to have and act out sexual fantasies. This lead to speculations that the addict group, made up of working-class or "macho" individuals, was more concerned with sexual performance while the non-addict group—described as a socioeconomically more privileged and "gayer" group—was more concerned with "sensuality/fantasy" sexual aspects.

Homosexual males enjoyed sex and drugs separately while the females combined the enjoyments of drugs and sex.

Judianne Densen-Gerber

Densen-Gerber gives up job at New York's Odyssey House

NEW YORK—The founder and director of Odyssey House, Dr. Judianne Densen-Gerber, has resigned as head of all city-financed Odyssey operations in New York City.

The resignation came in advance of a new report on Odyssey by the city's Addiction Services Agency (ASA), which, Dr. Densen-Gerber indicated will be highly critical of Odyssey's program.

"I don't believe in slavery or indentured servitude," she said. "I will not be told who I can and cannot treat."

The new director of New York Odyssey Houses is James Murphy, an ex-addict, who has been associated with Dr. Densen-Gerber and Odyssey since Odyssey's inception in 1966.

Dr. Densen-Gerber said she will assume the presidency of a parent corporation called Odyssey Institute. But, she said, she will play no direct role in supervising New York City Odyssey programs.

"I will conduct no treatment nor in any way guide the New York operation," Dr. Densen-Gerber said. "Mr. Jerome Hornblass (ASA Commissioner) has succeeded in driving out competence."

The report that appears to have triggered Dr. Densen-Gerber's resignation is the fifth on Odyssey prepared by or for ASA. Like those that preceded it (**The Journal**, June, 1974) this one, from all indications, will be highly critical of Odyssey.

The report had been delivered, confidentially, to Dr. Densen-Gerber and Odyssey and was to be returned to ASA, with any rebuttal comments that they wished to make, by late last month. It was then to be released to the press, following a policy established by Commissioner Hornblass that ASA's evaluations are in the public domain.

Dr. Densen-Gerber said the report is "filled with distortions and misunderstandings". She indicated that one complaint in the report is that she and other high Odyssey officials, who have been paid for 35 hours of work each week, do not spend 35 hours weekly working for New York City Odyssey projects. There are Odyssey facilities in several other states.

Dr. Densen-Gerber, in the past, has complained that evaluators sent to study Odyssey were professionally incompetent, particularly with reference to assessing its psychiatric services. Because of this criticism, a psychiatrist participated in the soon-to-be-released evaluation.

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Creating a monster

THE RECENT North American Congress on Alcohol and Drug Problems which attracted some 4,000 workers to glorious San Francisco (how many would have attended the congress had it been held in Podunk, U.S.A.?) provided ample opportunity for reflection.

To even the vaguely skeptical, it now appears one of the most crucial problems is coping with the huge, industrialized monster that is the alcohol and drug abuse field.

It is somewhat encouraging that at least some leaders are beginning to express concern about the pitfalls of empire building.

Some are going so far as to whisper frightening confessions —'we now have people with a vested interest in making the drug scene look worse than it really is'.

When drug abuse emerged as an international concern in the 1960s, the field was fraught with ignorance and shortcomings. In the process of developing sophistication, along with professional standards, the field inevitably became institutionalized.

As Senator Harold Hughes noted during the opening of the recent North American Congress:

"The alcohol and drug industrial complex is not as powerful as its military-industrial counterpart, but nonetheless there are striking similarities.

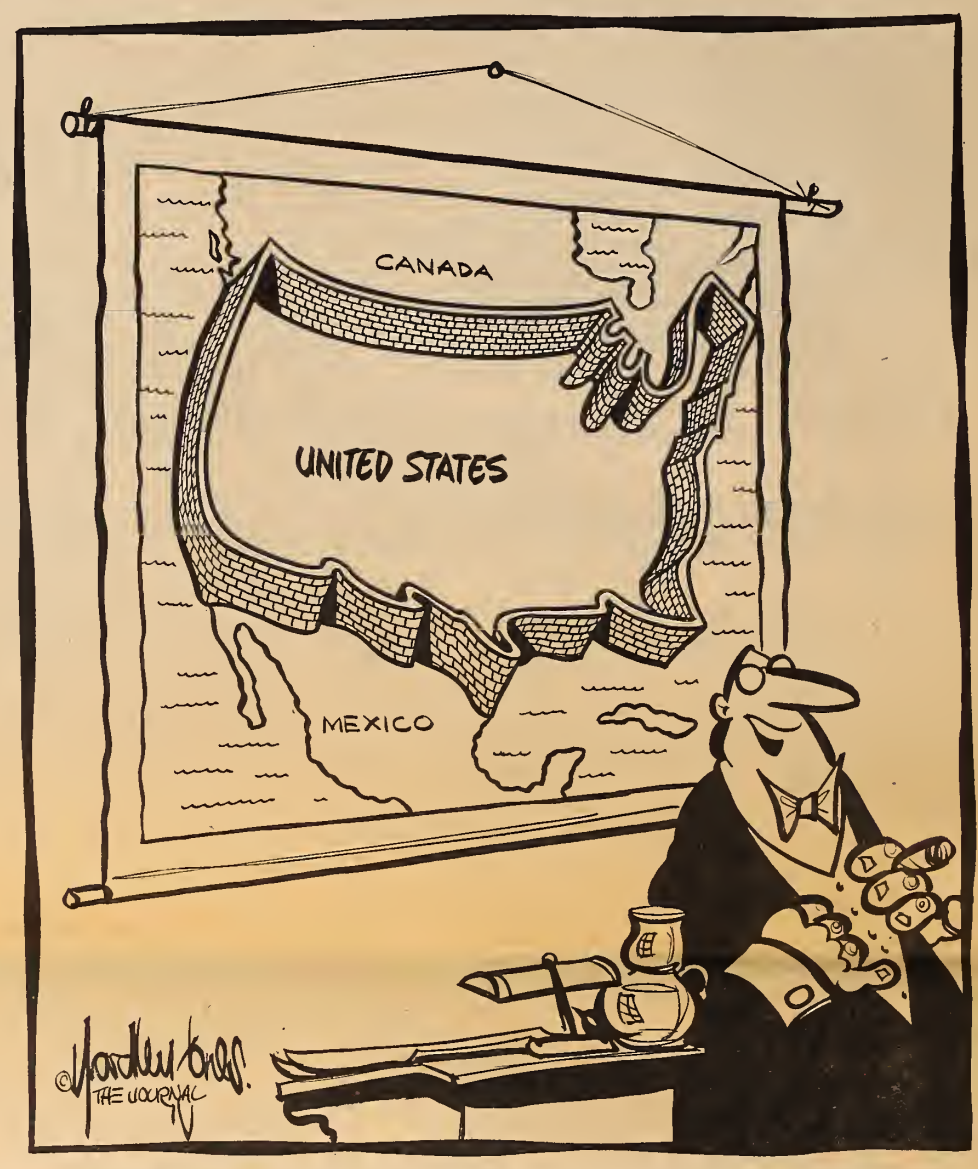
"We have the ever-enlarging structure of scientists, 'think-tank' personnel, administrators, governmental funding agencies, lobbyists, associations, consultants, evaluators, technical assistants, and so on.

"A huge and influential industrial empire produces most of the substances we are engaged in trying to control."

These are sobering thoughts from a man largely responsible for placing alcoholism on the map of respectability.

There is, of course, nothing intrinsically wrong with the whole development so long as workers can preserve their perspective, humility and professional integrity.

Perhaps the real answer lies in continual awareness of this problem of growth. Certainly, constant self-analysis is required.



"They said we couldn't solve the drug import problem but we did it!

Editorial Board welcome

THE JOURNAL is pleased to announce the appointment of three new members to the publication's Editorial Board.

They are:

Dr. David Smith, founder and medical director of the Haight-Ashbury Free Medical Clinic, San Francisco; Dr. Thomas Ungerleider, associate professor of psychiatry, UCLA Medical Centre; and Dr. Eugene LeBlanc, assistant head, research division, Addiction Research Foundation of Ontario.

We are confident our readers will continue to benefit from the contributions of the eminent members of our Editorial Board.

Letters to the Editor

Sir:

An article, "Spray Paint Inhalation A New Teenage Fad," which appeared in the November 1974 issue of **The Journal** has been brought to our attention.

We concur that it is indeed alarming that abuse of a normally safe and convenient product can lead to bodily damage and perhaps death. However, it is because of this need to inform and educate the public on the safe and proper use of aerosols that the Aerosol Education Bureau (AEB) was formed five years ago by the Ad Hoc Aerosol Committee as its informational and educational arm. Our extensive efforts have effectively reached hundreds of thousands of youth and adults.

To explain proper use, we at the bureau have produced and are distributing the pamphlet, "Safe Use of Aerosols Around the House." This pamphlet has been widely acclaimed by national associations including the National Coordinating Council on Drug Education, the American Red Cross, the National Conference of Parents and Teachers, and others. We are most eager to promote aerosol safety.

Daniel Leinweber
Aerosol Education Bureau
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A little reefer madness for Dr. Faustus

By WAYNE HOWELL

A DARK and stormy night. Alone in his laboratory, Dr. Faustus, marijuana researcher, looked about him and despaired.

His prospective study on cannabis use had come to grief for reasons various. His retrospective study had been savaged by his colleagues who had attacked his methods, his statistics, and his conclusions. His controlled group study had produced inconclusive results. His double-blind experiment had faltered because of inadequate controls. He sighed.

If only he could know the true facts about cannabis sativa. If only he could KNOW!

An anguished cry escaped his lips and he buried his despondent face in a pile of hard-won statistics which were, according to a learned colleague, not mathematically significant. Even as he did so, he felt a chill at the nape of his neck and noticed a strange sulfurous odour in his nostrils. When he looked up, there stood before him a tall dark stranger.

"Who are you?" demanded Faustus of the sinister apparition.

"They call me Mephistopheles," said the stranger softly. "I come to offer you the eternal truth about marijuana. Now and for evermore."

"But what must I offer in return?" asked Faustus, his heart fluttering like a caged sparrow in his chest.

"Your immortal soul, Dr. Faustus," whispered the stranger. "That is all I ask."

"No. No!" cried Faustus, tearing himself away from the Evil One's seductive gaze.

"Faustus—listen to me. Do you want to know once and for all if marijuana is a curse or a blessing to mankind? Do you want to know what really happens to a mortal being who smokes the weed for 10 years . . . 20 years . . . 30 years?

"Does it rot the brain? Or does it lead to aesthetic perceptions beyond the normal human ken? Does it shrivel the testes and engorge the breasts of youthful swains? Or does it elevate sexual sensation to a heavenly sphere? Does it calm anxieties? Or does it lead to neurosis?

"What about the amotivational syndrome anyway? Are reefers madness? Or are they sublime? Do you want to know, Dr. Faustus? Do you want to KNOW once and for all and for evermore?"

"Yes! Yes!" cried Faustus. Desire welled within his breast. Inchoate yearning seized his fevered imagination. (Or something like that did.)

"Faustus—listen to me. If we strike a bargain then you will KNOW. Compared to your knowledge, the combined knowledge of all the LeDain commissioners shall be as a grain of sand. Compared to your knowledge, all the intelligence in the volumes of the Addiction Research Foundation's library shall be as children's fairy tales," whispered Mephistopheles.

"It's a deal!" cried Faustus.

"Sign here in blood, or a ballpoint will do . . . there! The deed is done, now there is no escape from our awful covenant."

"Yes. Yes. Now give me the knowledge that I may KNOW," cried Faustus. Eagerness burst inside him like an exploding star (or something).

"Fine Faustus. First, let us deal with amotivational syndrome.

"According to Lucifer, who studied 586 fallen angels for a period of 18 months, there is absolutely no evidence marijuana causes such a syndrome. I would be less than candid, however, if I did not admit that some of his colleagues have questioned his findings and accused him of bias. Indeed, Moloch and Mammon, who have done some fine work in this area, say Lucifer did not take into account certain socio-economic variables in the sample group and they submit, on the basis of their findings—which by the way are not taken seriously by Screwtape's group—that there is a distinct possibility, yes even a probability, that amotivational syndrome may be a clinical entity. As to the question of memory loss Faustus—we can at the present time definitely postulate, barring any new evidence from Baalim, Chemos et al to the contrary, that there is reasonable possibility . . . Faustus? . . . Faustus? . . . Why are you weeping, Faustus?"

(Wayne Howell is an Ottawa physician and freelance writer.)

TREATMENT: Still a long way to go

By MILAN KORCOK

THE PROMISE has turned to frustration.

Despite the money, the politics, and the professional activity expended in the development of approaches such as methadone maintenance, therapeutic communities, and detoxification programs, the current state of drug abuse treatment is still sadly wanting.

There are still too many drug users with unmet needs slipping through the cracks.

As is claimed in a recent survey commissioned by the National Institute on Drug Abuse "... treatment for individuals involved with drugs (needs) to offer not only two or three approaches, but also a wide variety of modalities geared to highly specific needs that go beyond merely dealing with a person's propensity to consume drugs."

In effect, drug treatment emphasis to date has been too restricted, too narrowly defined, perhaps too intent on finding the one, single technique which would be the "answer" to all the problems of drug abuse.

The report, prepared by Metcor, Incorporated, under contract to the Division of Resource Development of NIDA, is a massive effort exceeding 2,000 pages and including chapters written by some of the most prominent drug treatment authorities in the field.

(The report is one of a series of assessments of treatment approaches commissioned by NIDA that will be emerging in the months to come.)

Fortunately, because of the report's bulk, a summary and overview of all the submissions was prepared by Dr. Peter Bourne, consultant to the Drug Abuse Council, Inc.; Dr. Donald Wesson, psychiatrist and chief of the West Coast Polydrug Project (associated with the Haight Ashbury clinics); Dr. David Smith, medical director of the HAFMC; and Jonica Homiller of Metcor.

The report not only assesses various new treatment methods but emphasizes the need to look at the whole continuum of treatment services, from the acute crisis stage of drug use, through the addict's rehabilitation and integration back into society.

The point is well made that to date, treatment efforts have been spurious, ill-planned, and concentrated on only small segments of that continuum.

The summary discusses this entire continuum particularly treatment and rehabilitation programs for specific populations—young people (and subgroups within), women with special needs, pregnant women, criminal users and diversion programs, homosexuals, ethnic, cultural and social groups, and others.

But among its most interesting recommendations are those reserved for a small group of relatively new individual treatment techniques which can be scientifically measured and which relate to the psychophysiological factors that induce drug seeking behavior.

These recommendations cover many variations of pharmacological treatment, among them Darvon N and propranolol, extend to acupuncture, biofeedback, hypnosis, meditation, and they even touch lightly on electrosleep, and nutritional therapy.

This is how the summary judges the potential of these various techniques:

Biofeedback - technique alters neurological and behavioral functions

• ACUPUNCTURE.

The recent use of acupuncture in the treatment of addiction dates from the work of Dr. H. L. Wen who in Hong Kong in 1972 alleviated withdrawal symptoms of 40 heroin and opium addicts treated on an inpatient basis for up to three weeks.

The technique involves applying acupuncture needles to the "lung" points of the ears and then attaching the needles to an electro stimulator for approximately 30 minutes.

This procedure does rapidly alleviate withdrawal symptoms, and although it has to be repeated with steadily decreasing frequency over a period of several days, it appears to be very effective in maintaining patients in relative comfort.

Slight variations, such as staple techniques, are used in certain locations in the United States.

Acupuncture does fit into the same constellation of treatment methods as transcendental meditation, hypnosis, and biofeedback. But it does appear to have a more direct physiological effect on the brain than do other "relaxation" techniques. Some believe that it acts by suppressing para sympathetic discharges in the hypothalamus.

The conclusion reached in the report is that acupuncture remains an apparently effective, but as yet inadequately researched and tested approach to treatment.

Acupuncture - needles applied to 'lung' points of the ear

• BIOFEEDBACK

This technique also appears to alter neurological and behavioral functions through either self-induced or technically-induced events.

A prime authority in this field, Dr. Joe Kamiya, of the University of California, contends that in the process of achieving self-control of physiological activity, the individual comes to discover many of the psychological variables of mood, attention level, and a variety of physiological and emotional sensations.

Kamiya suggests that biofeedback training effectively reduces anxiety levels, a prime motivating factor in the drug taking behaviour of many addicts.

At the same time he remains cautious about the potential of biofeedback in the concern that few addicts would want to become actively involved in such a long training process.

• HYPNOSIS

Hypnosis can link some aspects of drug-using behavior and the drug itself with nausea, anxiety and other aversive situations. It can also produce a re-living of the drug experience without the injection of drugs and it can allow the patient to go back to the pre-drug using years to relearn certain behavioral patterns.

To date, however, the data on hypnosis is entirely empirical and no matter how effective it might be in some patients, there is considerable doubt that it would be practical to implement on a large scale. As the summary suggests, hypnosis will always have to be limited to a relatively small number of competent practitioners of hypnosis.

• MEDITATION

The issue appears to be not whether transcendental meditation can be effective (given a highly motivated subject, it certainly can be), but how appealing this treatment methodology might be to a large, young population.

Dr. Herbert Benson, of Harvard, warns against the cultism which has surrounded the use of transcendental meditation. He says that the hypometabolic state achieved with this technique can be attained in a variety of other self-induced ways which are free of cultic, religious overtones.

There is nothing unique about transcendental meditation that makes it different from other meditation states, says Dr. Benson.

The physiological process involved in transcendental meditation seems in many ways to be similar to both hypnosis and biofeedback.

Acupuncture, hypnosis, meditation and biofeedback all have overlapping characteristics in that they are capable of inducing relaxation and reducing those phenomena that lead to drug use. However, all four approaches require a lot of interest and motivation within the patient.

"Limited appeal, not the efficacy of the technique, appears to remain the most serious problem in achieving widespread use of these treatment methods," says the report.

Besides recommending further investigation of these approaches to drug abuse treatment, the summary suggests more precise evaluations of some purely pharmacological techniques which are now getting a good deal of attention.

The summary says that despite all the attention paid to Darvon N, there is little evidence of a pharmacological nature that this chemical has anything to offer over more traditional drug substitution approaches. What it does have, however, is a remarkably high acceptance among some addict populations, an acceptance which is not granted methadone.

Consequently, the emphasis of further study in respect to Darvon should be directed to examining the reasons for this acceptance.

The use of propranolol has also received a good deal of attention recently but "on balance, this drug has very little to offer," says the summary.

A number of other pharmacological approaches to detoxification have been reported recently, insulin, haloperidol, Lomotil, Bionar. Other pharmacological agents as well as several variations of "cold turkey" have also been cropping up. But the report is clearly sceptical about their value.

"The refinement of existing pharmacological techniques and the ability to make them generally available, particularly for detoxification, is clearly more important and valid than searching for new chemical agents," declares the summary.

The report also comments on electrosleep (cerebral electro stimulation), and nutritional therapy, but finds investigations in these areas far too preliminary to make any conclusions.

In respect to the nutritional therapy, there is a lot of scepticism about the theory that metabolic imbalance, particularly hypovitaminosis and hypoglycemia contribute to the development of polydrug use.

It is acknowledged that heavy drug users tend to neglect their nutrition and appear debilitated when they present for treatment.

But the claim that nutritional imbalance is a cause of the drug use is still nothing more than a notion.

A device for massaging our own egos?

The ever-enlarging drug empire

By GARY SEIDLER

SAN FRANCISCO—A swan song or the ill-natured quack of a lame duck?

With that prefacing question, Senator Harold Hughes, chairman of the North American Congress on Alcohol and Drug Problems, presented some candid observations as to what the future may hold "in our national effort to combat chemical addictions".

Sen. Hughes, who is retiring from the United States Senate after 16 years as an elected official, said professionals in the field have "embarked on a new phase of a long struggle—a phase that has great and unprecedented potentials along with a few substantial hazards.

"However great our efforts, we now know we are not going to stamp out the use and abuse of dangerous substances.

"Realistically, we can't expect to conquer drug dependency as we conquered polio and tuberculosis. Perhaps all we can do is educate, minimize the damage, and make sure the measures we take don't compound the problems, as in the case when we retain criminal penalties for the use of marijuana."

Sen. Hughes told an opening session audience of some 2,000 that workers in the field must subject themselves to serious self-analysis.

Comparing the national undertaking in the alcohol/drug area to the waging of a war, Sen. Hughes said: "We have, in effect, a new civilian army that has now become institutionalized. The alcohol and drug industrial complex is not as powerful as its military-industrial counterpart, but nonetheless there are some striking similarities.

"We have a growing body of trained and skilled counsellors who are the soldiers in the field. We have the ever-enlarging structure of scientists, 'think-tank' personnel, administrators, governmental funding agencies, lobbyists, associations, consultants, evaluators, technical assistants, and so on.

"A huge and influential industrial empire produces most of the substances we are engaged in trying to control."

Sen. Hughes, largely responsible for the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, posed some sobering questions:

- Are (we) truly interested in helping human beings in need, or is our involvement a device for massaging our own egos by regimenting people in the guise of helping them?
- Do (we) feel ourselves beginning to surrender to the false glory of bureaucratic empire-building?
- Are (we) in the alcohol and drug treatment scene because we like the gamesmanship—the exhilaration of writing grant applications, running training programs, doling out money, travelling around giving advice, savoring the title of expert?
- Have (we) become so hidebound with our own methods and approaches to the problem that we can't fairly consider alternative methods?
- Do (we) feel ourselves drifting into the carping criticism syndrome—the stage where we sit back and find fault with the creative workers in the field, split hairs over the language of research findings, and wrangle fruitlessly over issues that don't make an ounce of difference to the sick person, the supposed beneficiary of all this effort?

"These are all human failings, but we can resist them as long as we are aware of their existence and are willing to subject ourselves to the necessary introspection."

Sen. Hughes said that while there is great reason for encouragement over the progress of the last few years, the remaining unknowns should suffice to keep workers from overconfidence.

Although much has been learned about addiction, success rates are still far too low in relation to the size of the overall effort . . . "in fact, we haven't even agreed on what 'success' itself is," he said.

"Also, we haven't yet learned how to orchestrate a comprehen-

Drug abuse-crime link documented

A STUDY of a more than 43,000 drug addicts who entered treatment programs between 1968 and 1973 has documented the heavy involvement of these abusers in criminal activities prior to treatment.

The study showed that more than 80% of the drug abusers had been arrested at least once, 66% had two or more arrests, 60% had one or more criminal convictions and 28% had been in prison for one or more years.

Dr. John Ball of Temple University Medical Center's department of psychiatry, Philadelphia, Pa., suggested results actually underestimate the criminal behavior of the subjects "as it is known that only a small proportion of criminal behavior results in apprehension and arrest".

For instance, he said, 43% of the male drug abusers and 34% of the females stated they had a steady illegal source of income. This demonstrates "the continual involvement in a criminal behavior pattern among these narcotic addicts".

While 80% of the overall patient population had been arrested prior to treatment, significant regional differences in arrest rates were noted, with rates higher on the East and West coasts and lower in the Midwest and South, he said.

A difference in prior criminality was also seen between male and female patients, with male patients more likely to have been arrested, to have had repeated arrests, to have been convicted, and to have been incarcerated, he said.

While 86% of the males had been arrested prior to treatment and most of them at least four times, only 77% of the females had been arrested and only 27% of these had four or more arrests, he said.

Also, while 54% of the males had been incarcerated for more than a month and 20% for at least three years, only 30% of the females had been in jail for at least a month and only 6% for three years or more, he continued.

Dr. Ball considered the finding that one-fifth of the males had been in jail for three years or longer was especially significant as it indicated "that a sizeable proportion of the male patients are deeply enmeshed in a criminal lifestyle".

He also said it was important to note that the findings do not support the hypothesis of "greater deviance or pathology" among the female drug abuse population.

The findings indicate the treatment of persistent drug abusers requires considerable attention to penal rehabilitation as well as to the illicit consumption of drugs," he emphasized.

Information for the study was obtained from the national data bank of treatment data at the Institute of Bebavioral Research, Fort Worth, Texas. The data bank contains some 200,000 records on the 43,000 patients included in the study.

Almost 4,000 people involved in the alcohol and drug field gathered in San Francisco, December 13-18, for what is believed to be the biggest conference of its kind ever held . . . The North American Congress on Alcohol and Drug Problems. THE JOURNAL will continue its coverage of this conference in its next issue.

Tough exterior a facade pregnant addict "vulnerable"

By MARY HAGER

WHILE SHE may appear as "a tough as nails street woman", the pregnant woman on methadone or heroin is as "vulnerable and sensitive as anyone".

She also faces some severe emotional crises which must be handled with compassion and understanding, says Arthur Maglin of Mount Sinai Hospital, New York.

Some of the crises, and some of the steps which may help to alleviate them, were outlined by Mr. Maglin.

One real source of anxiety for street mothers, he said, is they are likely to have their babies legally removed from their care since addicts are generally considered unfit to care for children. Often, he said, this is true as the addiction can cause the mother to put her drug needs ahead of her children's needs.

Another source of stress for mothers is the knowledge that their babies willl probably have withdrawal symptoms after birth, he continued.

In addition, many street addicts do little or nothing to prepare themselves for motherhood until the pregnancy is quite advanced, he said. This may be because they refuse to accept the pregnancy; or are ambivalent. In the case of heroin addiction, a woman may not know she is pregnant until her stomach makes it obvious, he continued.

Because the street addict so frequently refuses to acknowledge pregnancy, or because she actually doesn't know she is pregnant until the pregnancy is far advanced, abortion is frequently not an option, he noted.

And, since the pregnant addict is usually unwed, she must face the emotional crises involved with her pregnancy, alone. Many enroll in rehabilitation programs once pregnancy is discovered and get some support there, he added.

Maglin suggested mothers on methadone maintenance have some different, but very real problems. Sometimes they enter programs because of the new responsibility and sometimes because they need drugs but are no longer able to raise money through prostitution, he said.

The woman on methadone maintenance also must consider—and must be helped in her decision—whether she is mature enough to take care of a child, whether the child would conflict with her other goals, whether there is someone to share in child care responsibilities, whether adequate housing is available and whether there is financial support, he continued.

He said pregnant women who enter methadone programs usually do so late in pregnancy but that many women already in programs do become pregnant. Many of the latter group, Maglin added, are living with men also in the program who, contrary to most views, report increased sexual activity after joining the program.

Methadone mothers fear what methadone might mean to their children and often start adjusting dose levels, which can be damaging to the fetus, he cautions. No correlation between dosage levels in the mother and withdrawal symptoms in the infant has yet been shown, he added.

Methadone mothers often are anxious about whether they will be able to get off methadone before their children know that they were once "junkies," he said. Also, many are concerned that they are not legally married.

Maglin stressed that the expectant mother has to be told again and again that there is no evidence methadone is harmful to the child, aside from the withdrawal symptoms. Yet, they must also be told that like any other medication, methadone is not to be taken lightly and that careful supervision is necessary.

The mother also needs reassurance that her baby won't be taken away from her, which does occasionally happen in rehabilitation programs, he said. A social worker can prevent this by helping the mother prepare for and care for the baby adequately.

The social worker must also give emotional support without a judgmental attitude, he continued, and must "patiently repeat over and over" the information the mother needs to know such as keeping clinic appointments and avoiding irregularities in methedone dosage.

For alcoholics

Sexual counselli

BY HELPING the alcoholic accept himself as a person and adjust to his own sexuality, the counsellor may be removing the problem which could otherwise drive the alcoholic back to drink.

Jack E. Ryan, community alcoholism director for Youngstown, Ohio, suggested this type of counselling may be essential to the full recovery of the addict.

The average addict may never have made an adjustment to his sexuality, said Ryan.

He said he had noticed the problem in approximately 100 men between the ages of 25 and 35 who were successfully overcoming drug and alcohol abuse until they became involved in a relationship involving sex.

He defined "sexuality" as the quality which allows a man to relate to other people as a man, or a women to relate to other people as a woman.

Relating is the key, he suggested, since addicts probably never have learned to relate to other people. And while sexuality is the deepest expression of a personal relationship, addictive people tend to keep sex separate from relating, he said.

While the addict has learned the basics of sex, "it's quite possible he has never used sex without the presence of a mind-altering chemical".

The problem with alcohol begins in teen years, frequently to give an individual the "nerve to make out" with a member of the opposite sex: The primary aim is personal gratification, not the satisfaction of his partner, he said.

When this individual sobers up, years later "he has to face the fact he has always used sex selfishly.

"You have often heard it said that the emotional development of an alcoholic stops when he begins to use chemicals, and does not start again until the drinking stops," he said.

"Therefore, we have a chronologically and biologically mature individual who is emotionally still a kid. He has used sex selfishly

Women shun th during pregnan

WOMEN WHO drink cut their alcohol consumption nearly in half during pregnancy, a study of 156 women has shown.

The average alcohol consumption dropped, in the group, from about five standard highballs per week before pregnancy to two during pregnancy, the study revealed.

Ruth E. Little of Johns Hopkins University and Francia A. Schultz of the University of Washington reported that most of the women in the study drank "just to be sociable" although about one-third of them said alcohol helped them to relax.

The study also showed beer was the favorite beverage of the heavy drinkers—those who had five or more drinks at least several times a week—while none of the women drank wine heavily.

Harold Hughes

sive social policy for dealing with alcohol and drug problems—the most effective mix of criminal law enforcement, education, treatment, the use of legal controls on availability, and changes in social environment, to minimize the damage of substance abuse."

Treatment programs must recognize "special" needs of women addicts

By MARY HAGER

ARE THERE distinct patterns of drug abuse peculiar to women?

Do women drug addicts have special treatment needs which are not being met?

Not surprisingly, a number of people think the answer to these questions is yes and some of them explained why at the congress.

Marsha Martin, a drug program coordinator from Sacramento, Cal., identified several patterns of drug abuse she felt were peculiar to females and which have distinct implications for treatment.

The woman alcoholic, she said, has played her traditional feminine role, nurturing and caring for her family, but once her children leave, she turns to alcohol to combat her loneliness, anger and depression.

A large number of women become addicted to such legal and quasi-legal drugs as barbiturates, sedative hypnotics, diet pills, and pep pills, frequently given to them by their physicians as an acceptable way to solve the "emotional stress" to which women are considered especially vulnerable, she said.

The female narcotics abuser is invariably someone's "old lady" who has been "exploited by men" and has become addicted because of her involvement with men, she said.

She suggested the feminist movement will have a strong impact both on women addicts who seek treatment and on the type of treatment they receive.

Women who are aware of the sex stereotype problems will examine their own personal goals and motives, be better equipped to handle their own rehabilitation, and be ready to move in new directions, she said.

More women are now seeking treatment even though many elements of society seek to protect the woman addict, she said, explaining that women addicts are often arrested on other charges and that physicians often treat women addicts for "emotional distress" or some "psychoneurotic condition" in an attempt to shield her from the stigma of drug abuse.

This, she said, only prolongs the problem and physicians ought to "eliminate the idea that a woman needs chemical help for stress".

In terms of treatment, women ought to have their own living quarters and child care services should be available. Also, she said, the number of women on the treatment staff should be proportional to the number of women in treatment.

Esta Solder, who surveyed a number of women in treatment at the mental health center in New Haven, Conn., reported that the women felt they were treated as "sluts" or "whores" by the treatment staff, regardless of their backgrounds and simply because they were addicts.

The women in treatment said they were given contradictory images: While the image of the straight, middle-class woman, the "monogomous, lady-like housewife", was extolled, male counsellors, at the same time, tried to seduce female patients, she said.

Few of the women said they were encouraged to be independent or creative and few found positive aspects in treatment, although some found at least one staff member interested in them as individuals.

Treatment programs will always be difficult for women as long as the programs try to tell them what they are and who they ought to be, she stated.

In a survey of drug-use among middle-aged housewives in a Massachusetts community, John S. Down of the department of mental health discovered that a substantial number of women use mood-altering medications, but do not view these medications as a problem for themselves.

The survey included women in 150 households, of whom 19% reported using mood-altering medications. Most commonly used were diazepam, chloridiazepoxide hydrochloride and butalbital. More than half used the medications for emotional problems while the others took the medications for physical reasons.

Less than half took the drugs daily and 75% had taken the drug for more than a year. Yet only two of the women felt the medication was a problem and none felt they were dependent.

Four women in the study said they drank more than twice a week and none of the women reported the use of illicit drugs, he said.

The study did not indicate a substantial group of women who abuse medication but do not seek treatment, he said. None of the women had any desire to discuss their use of medication with a social worker or a self-help group and none felt they were abusing drugs.

He defined two significant differences between the women who used the mood-altering drugs and those who did not.

The women who used the drugs were, first, more likely to have friends who used similar medications and second, less likely to have children living at home than those who did not. No other significant differences between the two groups were noted, he said.

lling "a must"

and unemotionally for years."

Ryan contended that the self-image of the alcoholic decreased as the drinking increased and since the alcoholic couldn't love himself, he could not love anyone else, or accept love.

Homosexual encounters during addiction can also cloud the sexual identity of the alcoholic, he said.

He advised counsellors who ...e not "come to grips" with their own sexuality to refer the alcoholic to someone more capable of dealing with the problem.

Sobriety in a married couple may disclose a non-alcoholic partner who is chronologically and emotionally aged 40 and an alcoholic partner who is chronologically aged 40 but emotionally 17, he noted.

The idea that the alcoholic has to be a "man" may be a new and frightening experience as he realizes that another person really loves him and wants to know and be involved with him, he continued.

The single recovering alcoholic may need to understand that a relationship must be developed on many levels before a sexual encounter is involved. This is particularly difficult for someone used to bar-room romances, since he will have trouble understanding that someone will accept him as he is and that he does not need to prove himself, he said.

The alcoholic who had homosexual involvements may help find his identity by recalling who he watches walk down a street or what ads catch his eye, he continued.

The counsellor, Ryan noted, should help the alcoholic to realize "that he is a person for whom sex activity is a viable but not a required option".

30 years old: at the brink

THIRTY IS the magic age, the turning point which determines whether a heavy drinker will or will not become an alcoholic, studies suggest.

Discussing evidence for the role of heredity in the alcohol and drug fields, Mr. Mark Schuckit of the University of California San Diego School of Medicine, said in this society males between the ages of 18 and 25 tend to drink heavily.

Anyone who has a predisposition to drinking doesn't have to seek alcohol for any reason if he is normal, he continued.

But by the age of 30, the alcoholic continues to drink, and drink heavily, while the non-alcoholic doesn't, he said.

Schuckit said studies on the role of heredity in the development of alcoholism have been contradictory and have not provided a definitive answer.

Twin studies have shown a significantly higher association in identical than non-identical twins in alcoholic populations, he said. Also, in some families alcoholism and alcoholic tendencies seem to vary with a specific genetic market, he noted.

Studies of half siblings who had a single alcoholic parent but were raised separately have shown that the biological alcoholic parent was a more important factor in predisposition to alcoholism than either a broken home or the drinking habits of the parent who raised the child, he reported.

Yet, the person with a biologic alcoholic parent who was raised by another alcoholic parent had a lower risk for alcoholism than the person with the biologic alcoholic parent who was raised by a non-alcoholic parent. This suggests that those raised in an alcoholic family have a first-hand warning and stay away from alcohol, despite a predisposition, he said.

shun the bottle egnancy: study

Prior to pregnancy, 12 of the group were classified as heavy drinkers and 24 as abstainers. By the eighth month of pregnancy, the number of heavy drinkers had dropped to three and of abstainers risen to 36.

Age and parity did not appear related to drinking during pregnancy, although women with fewer children tended to drink more during pregnancy, Ms. Little said.

However, a relationship was noted between alcohol consumption and smoking and this persisted throughout pregnancy. The women who consumed the most alcohol were also the heaviest smokers. A possible relationship between heavy use of alcohol and use of psychoactive drugs during pregnancy was also noted.

Fetal growth affected by methadone dosage

THE SIZE of the baby born to a mother taking methadone during pregnancy appears related to the size of the dose during the first trimester.

As analysis of birth weights and use of heroin or methadone by the mother during pregnancy at the Albert Einstein College of Medicine in the Bronx, New York, has shown that the larger the dose of methadone in the first trimester of pregnancy, the larger the baby.

Dr. Stephen R. Kandall of the department of pediatrics, suggested it could be due to one of three causes—altered fetal carbohydrate metabolism leading to hyperglycemia, (the same mechanism which frequently leads to the overgrowth of the babies of diabetic mothers); endocrine changes involving a pattern of adrenal hyperfunction and fetal overgrowth; or a change in the cell number.

Dr. Kandall said the finding raises some important questions in the management of an addict's pregnancy.

The study also showed that infants born to mothers using heroin during pregnancy were of low birth weight, although most of the babies were born at or near term, he said. This suggested that heroin affected fetal growth rather than the length of gestation.

Birth weights were also low in mothers who said they were ex-heroin users, suggesting that past heroin abuse also contributes to growth retardation of the fetus, Dr. Kandall said. This would mean heroin causes physiologic or biochemical changes extending beyond the period of addiction, he noted.

The study involved a review of more than 6,600 births, 207 of them to mothers using heroin and/or methadone.

Of the 207 infants, only those born to mothers who had used heroin in the past had no withdrawal symptoms, Dr. Kandall said.

Raise standards or lose financial support: ASA boss

DRUG PROGRAMS in the United States risk losing federal, state, and municipal support in the current recession if they do not raise their standards.

This warning was delivered to the North American Congress on Alcohol and Drug Problems by Jerome Hornblass, commissioner of New York's Addiction Services Agency.

Hornblass, whose $80 million-a-year agency funds and directs 160 drug programs caring for 52,000 addicts, said the drying up of funds threatens the existence of rehabilitation programs unless there is commitment to prove to the public and funding authorities that the work being done is "meaningful".

"We can no longer afford slipshod programs that promise much but deliver little. The drug programs that survive the recession economy will be those that operate according to professional standards, that keep clear up-to-date treatment records, that keep accurate detailed financial records, that have dedicated staffs more interested in the welfare of clients than in building little empires or proving their philosophy of treatment."

Jerome Hornblass

Speaking at a panel discussion examining trends in drug programming, Hornblass said the growth of drug programs has meant local and state agencies are now faced with the problem of providing jobs for rehabilitated addicts. "... true rehabilitation implies freedom from dependency in all its forms, including drugs and alcohol, but also dependency on welfare".

He said a major effort is now underway in New York City to provide basic education for addicts in treatment because research has shown many cannot read or write well enough to work at available jobs.

Hornblass also stressed the necessity of upgrading clinical standards in most programs run by former addicts. The typical drug abuser in 1974 in treatment is mentally sicker than the heroin addict of the 1960's, and diagnostic and treatment standards must be upgraded to deal with this new type of client.

A SPECIAL REPORT

Ukraine drug abuse

—'a hideous leprosy'

THE FOLLOWING article on drug abuse in the Ukraine, was written exclusively for *The Journal* by Laura Stump of the New York State Drug Abuse Control Commission.

It is based largely on an interview, conducted through an interpreter, with four officials in the Ministry of Public Health, Kiev.

By LAURA STUMP

"We view narcotic addiction as more than just a public health problem. It is a hideous leprosy in our society which must be eradicated."

The speaker is Dr. Vsevelod Kozluk, head of the department of prophylactic medicine, Ministry of Public Health, Ukrainian Soviet Socialist Republic.

To this end, the force of social pressure is backed by police powers, presenting the addict with Hobson's choice—treatment on a voluntary basis or "compulsory isolation".

Identifying the drug abuser and taking the necessary action is considered the social responsibility of his fellow workers and neighbors.

A poor work performance is usually the first clue that an individual is a drug abuser. Other indications may be revealed at periodic medical check-ups in factories or in the course of arrest for some criminal involvement.

Pressure is applied on the family to convince the individual voluntarily to enter treatment at a local psychiatric clinic. Failing this, he is brought up on charges at a meeting of the local governing council.

Once the decision of compulsory commitment is arrived at, he is placed immediately in police custody to await transportation and admission to the main narcotic treatment centre.

This facility, which serves the whole of the Ukraine, is on the grounds of a large psychiatric hospital outside Kiev.

The period of commitment is for five years of which the first one or two are spent in "compulsory isolation". This is followed by a period of aftercare with periodic reporting to the nearest local psychiatric clinic.

The aim is total physiological and psychological rehabilitation. The cornerstones of the program are hard work and intensive therapy. "We believe work makes the man."

Detoxification is accomplished by gradually reduced dosages of morphine. Methadone is not held in high esteem.

For the first six months of treatment the addict is almost totally isolated from the rest of society. Visitors and gift packages are prohibited.

"We don't want to make things easy or pleasant for him."

Work assignments are paid for at the prevailing wage. However, the individual must pay for his room and board at the treatment center: The remainder is sent to his family.

Addicts committed on an involuntary basis are not eligible for medical insurance benefits.

A minimum of two therapy sessions daily with a psychiatrist or psychologist is a required part of the treatment program. In addition, a psychiatrist is on call 24 hours a day.

All therapy is on an individual basis. "We don't feel group therapy has any effect with drug addicts."

Staff workers at the facility are carefully screened. "We don't want anyone around who might be influenced by the addicts."

Security precautions are rigid—the responsibility of the police force.

According to Dr. Jeanne Koretzky, specialist in psychiatry for the Ministry of Public Health, it takes at least a year of treatment for an addict to progress to the point where he can withstand those pressures of the "outside" world that contributed to his addiction.

At the time of this interview, 46 patients were in the first stage of treatment and about 250 were in aftercare. A client reverting to drug use while in aftercare is immediately readmitted to the closed treatment centre. Rarely is urinalysis used to determine reversion to drug use.

"We know all the techniques you use. We can do them too. But we feel an experienced psychiatrist who knows his patients can immediately spot any drug use."

Said Dr. Koretzky: "We can 'declassify' 90% of those we've treated if we get them into treatment within the first year of addiction.

"It becomes much more difficult the longer they've been addicted. And there are a few whom we're never going to be able to turn around."

Almost all of the addicts are males. The average age is close to 30. Most have criminal records and a history of drifting from one job to another.

Dr. Kozluk credits an intensive sports program and participation in cultural events for the almost complete absence of teenage addiction.

"We keep our youngsters too busy for them to develop 'unhealthy interests'."

Though the country has an intensive education campaign to combat the spread of alcoholism (which is regarded as separate and apart from drug use), there are no such efforts in the area of drug abuse.

"The problem is minuscule," said Dr. Kozluk, "and we're afraid if we start showing films about drug abuse we might develop a 'morbid curiosity' where none now exists."

The penalties for inducing others to use narcotics are stiff—five to 10 years in prison—with the possibility of a life sentence for involving minors in drug abuse, according to Dr. Kozluk.

Morphine is the primary drug of abuse and Dr. Kozluk said that, in the past, too many citizens became morphine addicts through irresponsible prescribing of the drug by physicians. The medically-addicted form a separate category and are maintained on the drug.

Though denying other drugs of abuse, Dr. Kozluk mentioned barbiturates are as rigidly controlled as morphine and stressed research efforts being made to find satisfactory pharmacological substitutes for both morphine and barbiturates. Heroin, he claimed, is unknown in the Soviet Union.

Professing he knew nothing about the drug scene outside of the Ukranian Republic, Dr. Kozluk nonetheless admitted to having heard of black market traffic in drugs in port cities, placing the onus for this on "seamen and other foreigners".

From unofficial sources one hears of hashish smuggling across the borders of the Trans Caucasian and Central Asian republics and the manufacture of hallucinogens in scientific institutes which, along with the illegally diverted medicinal drugs, are the stock in the black market drug trade.

Supposedly, the use of marijuana is fairly widespread among artists and university students.

Several university students questioned on whether they felt they had a social responsibility to report drug use among their peers, answered a unanimous "no". As long as it didn't harm anyone else, drug use was a "private affair", they said.

'Exploiting the sensational'

French press 'useless' in fight against drugs

By LYNN PAYER

STRASBOURG, FRANCE—With the exception of a few serious newspapers and articles, the French press has been useless, or even positively damaging, to the cause of fighting drugs, Maxime Florio of the French Ministry of Justice, told the 11th Conference of Directors of Criminological Research Institutes here.

The charge was made partly on the basis of two studies performed in France in 1971. The first dealt with the press itself, and the second with how it was interpreted by young people, Mr. Florio said.

The first, an analysis of five major Paris dailies in the second half of 1971, was made by Dominique Vaille. She found that although there had been no ideological exploitation of the drug phenomenon by the five papers of diverging political slants, there had been exploitation of the sensational.

They attempted to appeal to their readers with an unpleasant subject: "They accordingly condemned narcotics 'pushers' and addicts, dramatized situations, tried to compete with filmed information, looked for picturesque and sensational angles, over-simplified facts rather than took pains to explain them, and printed information that had not been checked and so was inaccurate.

On the whole, there was an abundance of odd news items but few efforts to explain the phenomenon."

The study accused the press of accentuating the natural youth-adult conflict. It also found that readers less than 25 years old formed no more than 7%-23% of the total readership, depending on the newspaper, whereas 80% of drug addicts were under 25.

The second study. *Les Lyceens devant la drogue*, by Dr. F. Davidson, M. Choquet and M. Depagne, found that only 30%-49% of the lyceens (high school students in an academically-oriented program) surveyed, read a daily newspaper.

Sixty per cent challenged the effectiveness of information campaigns even when they were totally opposed to drugs themselves; of these, 15%-19% thought that such campaigns encouraged people to experiment with drugs.

Between 62% and 71% thought those in control of the mass communications media were more interested in punishing than in understanding.

Mr. Florio said the situation in other European countries is, in many ways, similar to that in France. The often considerable activity of the media has been considered definitely damaging in Norway and Sweden, and difficult to evaluate in West Germany. In only one country, Austria, did it seem useful, he added.

He also cited a study in Italy by Luigi Cancrini showing that the press there had exploited the myth of the 'long-haired, dirty, delinquent, weak, ailing, perverted, left-wing, trouble-making addict'.

In contrast to the generally negative actions of the mass media, Mr. Florio said, the underground press had sought to provide its readers with objective information on drugs and on what it meant to use them.

Athletes will be screened

LONDON—Tests for traces of the muscle building anabolic steroids will, in future, be performed at meetings under the European Athletic Association.

Anabolic steroids have long been banned but have been used by most top athletes in events where muscles count,such as the shot-put, discus, hammer, and weight-lifting.

The weight-inducing drugs carry serious health risks including the possibility of jaundice, gallstones, and, in women, more marked masculine characteristics.

Until recently the drug could not be traced in guilty athletes. Now, however, doctors at St. Thomas' Hospital, London, have developed a test which is effective. It was given a trial run at the last Commonwealth Games in Christchurch, New Zealand.

Athletes were told they would be tested in the European athletic championships in Rome earlier this year but the threat was not implemented. Starting with the European Indoor Championships in Poland in March, however, tests will be routine. Any athlete found with traces of the steroid will be disqualified.

Several disadvantages are already apparent: European athletes will be at a great disadvantage in competing against North Americans if similar steps are not taken there. And, if athletes stop taking the steroids a few weeks before the meetings, no traces will be found in their urine.

Athletic officials are hoping the threat of life-long disqualification will be enough to stop what is now a world-wide problem in athletics.

Major campaign for Glasgow

EDINBURGH—A major campaign against alcoholism in Scotland, which has the highest rate in the United Kingdom, is being planned for early 1975.

The campaign will centre on Glasgow and cost $105,000 in its first stages.

One of the objectives is to remove the stigma which is attached to alcoholism in Scotland, often for religious reasons.

Israel moves up

JERUSALEM—About 1,000 people in Israel are now using hard drugs, Dr Ludwig Tramer, head of mental health services in the Ministry of Health here, has told the Knesset (Parliament).

On a percentage basis, he said, that puts Israel in the same league as France, Italy, England and Canada. However, the problem in Israel is still less serious than in the United States, Japan or Sweden.

He said figures did not include hashish users as no recent surveys in this area have been done. However, the "feeling" is that hashish use is declining, he said.

China-USSR drugs clash

THE SOVIET press is broadening its campaign against China by accusing Peking of taking part in large-scale narcotics trafficking in order to earn huge profits in foreign currency.

Pravda, the official Communist party newspaper, recently contended that the Chinese leadership wanted to preserve Macao as a Portuguese colony because the enclave, on China's southeastern coast, was a key outlet for an opium-smuggling operation by Peking in Southeast Asia.

Previously, according to a report in The New York Times (Nov. 18, 1974), the Soviet press sought to link Peking to drug-peddling through selective quotes from foreign press.

The Times report speculates: "The new accusations backed, Pravda says, by details, suggest the Russians are prepared to go further."

Meanwhile, a November issue of a magazine published by the young Communist League, includes an article on narcotics traffic charging that China built up her arsenal of nuclear weapons with the help of narcotics sales.

The article, according to The New York Times, asserts that China's trade in narcotics has grown to more than double her official foreign trade turnover and that the Chinese are responsible for most of the heroin that is sold in the United States.

The writer of the Molodaya Gvardiya article described the United States as the epicentre of world drug addiction", says The Times.

It further quotes the article: 'Just like the American Mafia, the Chinese leaders are actively engaged in selling opium and narcotics because of the fabulous profits. The difference is only how they use their profits.'

More laymen playing 'Dr.'

GENEVA—A "new phenomenon", of self-treatment not only with over-the-counter remedies but with prescribed drugs, must be studied and controlled, a Hungarian expert warned here at an international conference.

Prof. I. J. Bayer, director, National Institute for Pharmacy, Budapest, said more information and better "safety requirements" are needed in all countries.

He would ban all drug advertising to the general public, further restrict availability of drugs, and intensify educational efforts.

The conference, on drug control and evaluation, was sponsored by the World Health Organization's European Region and held in Heidelberg under a grant from the Federal Republic of Germany. Almost 50 experts from 24 countries and agencies participated.

Prof. Bayer saw two forms of growing "misuse".

"The patient often 'persuades' the medical practitioner to prescribe a medication that the patient himself has chosen," he said.

"The patient also makes use of drugs that have been prescribed, paid for by his (insurance or) national health service, and accumulated as 'household stocks'."

Doctors have not paid sufficient attention to the phenomenon, the official said. Minor tranquillizers were called the most striking example and allegedly "liberally prescribed without much thought by practitioners, often at the patient's request, because they are 'relatively harmless'."

Hungary has long been a major producer of pharmaceuticals and is often openly called the "drug factory of the East".

"Pharmacists could also contribute very valuably to improving our knowledge of the true situation with regard to self-medication," Prof. Bayer said.

"Their observations on trends and patterns in drug taking should be systematically collected. Such 'drug consumption monitoring' could be undertaken as a pilot project for one or two types such as hypnotics, sedatives and tranquillizers. . . . Studies of this type are badly needed, as they could provide doctors and authorities with the data we need."

Eastern as well as Western countries' professions and authorities have campaigned periodically to make people destroy or turn in all old prescribed and other medication in family cabinets. In one collection in an English town recently, a 50 year old preparation against worms, an older anti-snake venom, and *thalidomide*

"The pharmacists are crucial," Prof. Bayer said, "as health educators in the medicines sector. Their key position in self-medication must be enlarged to include the misuse of prescriptions.

"The general public is not competent to make a diagnosis, to choose the appropriate drug for a complaint, to establish the correct dosage or to evaluate the results of treatment. There are no 'good drugs' and 'bad drugs'. They are not like other 'consumer goods', and talk of 'dangerous' or 'harmless' drugs is meaningless when laymen choose them. . . .

"Self-treatment has always existed . . . and cannot be prevented. . . . All that health professionals can do is to try to defend public health by restraining laymen. . . .

"Health policy is wrong when based only on pharmacology. . . .

Alcohol-cancer link; evidence accumulates

FLORENCE, ITALY—A positive association between alcohol consumption and the morbidity (disease rate) of cancers of the pharynx, esophagus and liver has been found among two groups of Finnish men who are alcohol abusers.

The study, reported to the XIth International Cancer Congress here, was carried out in two parts by Dr. T. Hakulinen and his colleagues at the Finnish Cancer Registry in Helsinki.

In the first part of the study, the files of the cancer registry on cancers of the esophagus, liver, colon, and lung, in men during 1965-68, were compared with the names on the registry of alcohol abusers of the State Alcohol Monopoly.

The alcohol registry consists of some 200,000 men who have been registered following conviction for drunkenness under sanctions imposed by municipal welfare boards, or for breach of the regulations covering alcohol use and purchase.

Dr. Hakulinen said excessive morbidity in the men who were on the State Alcohol Registry was found for cancers of the esophagus, liver, and lung but not of the colon.

The second part of the study concerned a group of skid row alcoholics in Helsinki who were among the 4,400 registered alcoholics over the age of 30.

Dr. Hakulinen said that a person in Finland can be registered as a chronic abuser of alcohol if he has come into custody of a drug abuse organization or has been sent, or voluntarily applied, to a welfare institution for treatment of alcoholism, or brought to a labor exchange on the basis of vagrancy laws.

When the skid row alcholics were compared with the people on the cancer registry for 1969-70, an excessive morbidity was found in them of cancers of the pharynx, esophagus and lung. And overall their total morbidity of all cancers was higher than expected.

Dr. Hakulinen said that the excess morbidity of lung cancer as well as that of the esophagus may be attributed to parallel heavy smoking.

Around the world

PUBLIC FLOGGING

Muslims and non-Muslims alike will be liable to between 10 and 40 strokes of the birch for drinking, selling, possessing, or making alcohol under a new law in Libya. The law was promulgated by the government in accordance with the principles of Islamic law. Last year Muammar Al-Kaddaffi, Libya's leader, had his government revive a 1,400-year-old Islamic religious law under which adulterers and fornicators will be liable to imprisonment and public flogging. Another new law calls for amputation of a convicted thief's right hand.

SURE CURE

Russian scientists claim to have discovered a pill that is capable of making even heavy smokers quit within three weeks. Trud, a trade union newspaper, reports extensive tests have proven that eight out of ten chronic smokers were able to quit smoking after a 20-day course using the pill which is based on the alkaloid of anabazin sulphate, an insecticide commonly used in the USSR. The government has given approval for commercial production of the pill.

ALTERNATIVE PRISON

The Portia Trust is asking more than 20 British temperance societies to help set up a treatment center for alcoholics as an alternative to prison. The group believes that perhaps half the UK's prisoners have alcohol problems. It also claims that instead of the $93 a week spent on each person in prison, an alcoholic treatment center could operate at a cost of about $65 per person per week. The trust is trying to raise about $115,000 to build a center somewhere in the north of England, complete with a fence and security system to quell fears that the inmates would "escape and roam the country".

SMOKING BANNED

Venezuela, with the highest consumption rate of cigarettes per capita in South America, has just passed a new anti-smoking law. It is now forbidden to smoke in trains, planes, buses, theaters, movie houses, museums, supermarkets, hospitals and any other closed places where people gather. The fines for breaking the law range from $230 to $1,100. Officials hope this law will cut down on Venezuela's consumption of 2,064 cigarettes per year, per person.

Alcohol among Chinese

New evidence destroys old myths

By LACHLAN MacQUARRIE

HONG KONG—New evidence suggests alcoholism among the four million Chinese here is not as rare as was formerly believed and that its incidence may indeed be increasing.

A common impression has been that although Chinese may consume alcohol in large amounts and in various forms, they do not become alcoholics.

However, according to Dr K Singer, professor of psychiatry, Hong Kong University, most literature on Chinese drinking patterns has been "impressionistic and anecdotal".

The few clinical studies which have been done, have examined alcoholism among Chinese in such places as New York or Hawaii where they are a non-indigenous, minority population, writes Dr Singer in the Hong Kong Mental Health Association's publication, *Aspects of Mental Health in Hong Kong*.

Dr Singer studied the drinking patterns of the Chinese in Hong Kong where they are in the majority and the indigenous population, but where there are unique combinations of Chinese and Western influences.

He concludes that while the incidence of alcoholism here is not high, there are signs it may be increasing.

Traditional Chinese attitudes and beliefs about alcohol are mixed. On the one hand, alcohol is believed to help digestion, to improve the complexion, and to increase blood circulation and blood production.

Certain Chinese wines are customarily taken by women after childbirth in order to "improve the blood".

On the other hand, it is widely believed that alcohol has such harmful effects as shortening the life span, impairment of fertility and sexual performance, and predisposition to physical illness.

Dr. Singer says "the Chinese regard drinking as immoral but do not feel strongly about it". There is little public concern with drinking or alcoholism as a problem, but aggressive behavior and public drunkenness are looked upon with disfavour, he notes.

Both Chinese and Western alcoholic beverages are available in Hong Kong. The Chinese types are mostly wines made from rice or millet and with such ingredients as rose petals, tiger bone, preserved snakes, and various herbs for flavor or medicinal potency.

Western beverages are considered by some Chinese here to be more palatable and prestigious: They are certainly more expensive. Whisky and brandy, which are considered to have medicinal qualities, are the most popular of Western beverages.

For the 10-year period from 1960 to 1970, Dr. Singer notes, consumption of Chinese beverages has remained fairly constant. However, consumption of Western types has steadily increased to the point where the total consumption of both types by adult males in Hong Kong may not be much less than consumption by U.S. males.

Despite this increase, alcoholism in Hong Kong, unlike narcotic addiction, has so far not been a major social problem. Law enforcement officials consider the relationship between drinking and criminal offences to be negligible: Less than 2% of all arrests involve excessive drinking. The incidence of alcoholic cirrhosis has not been high. Apart from Hong Kong's psychiatric hospital, there are no facilities for prevention and treatment. An Alcoholics Anonymous group does exist in Hong Kong but it is made up mainly of expatriates rather than local Chinese.

While warning of the dangers of speculation in explaining this low rate of alcoholism, Dr. Singer singles out for special mention "the traditional Chinese socio-cultural structure, informed by Confucian philosophy which proscribes excesses, teaches propriety in interpersonal behavior, and stresses emotional control rather than emotional display".

The restriction of drinking to meals and the lack of drinking-centred institutions and groups may also be significant he says.

Under Western influence some bars have been established in Hong Kong, but these are mostly patronized by tourists and expatriates.

In community 'laboratory'

'Smoking Sam' leads concerted effort

By SAUL ABEL

SAN DIEGO, CAL.—A significant drop in cigarette smoking among junior and senior high school students in San Diego, in a period when smoking was increasing among the same age groups

Charles Althafer

nationally, has been reported in a community laboratory project here.

Project coordinator, Charles Althafer, told **The Journal** that evaluation data gathered from student and adult samples in the community too, reflected "meaningful progress toward the project goal of reducing cigarette consumption in San Diego county".

Among San Diego students in grades seven through twelve, the percentage of boys smoking cigarettes dropped substantially in all grade levels in the preceding five years, Althafer said.

Among tenth grade boys, the figure fell from 31.8% to 19.7%. Among seventh grade boys, it dropped from 16.9% to 9.5%.

The proportion of girls smoking cigarettes increased in grades 7-10, but decreased in 11 and 12. In the same 1967-71 period, percentages nationally were increasing for both boys and girls.

The San Diego community laboratory is a joint pilot project of the National Cancer Institute and the National Clearinghouse for Smoking and Health.

Designed to determine how anti-smoking techniques can be adapted for cancer control on a community basis, the smoking research and education project was conducted on a contract basis by a consortium of agencies and organizations.

The county medical society served as contractor, supported by the San Diego County Council on Smoking and Health. Council members, in addition to the county medical society, include the city and county schools, the Department of Public Health, the San Diego Cancer Society, the San Diego Heart Association and the San Diego Lung Association.

The San Diego County Council on Smoking and Health further broadened the community base of the project by organizing five commissions—schools, adult community, health professionals, mass media and the military. These were composed of interested citizens, many of them non-agency "consumers", who helped plan and conduct programs in their schools, industries, community organizations and professional groups.

The "poly-group" format developed a pattern of mutual reinforcement of smoking information by areas of overlap.

Good school programs, for example, were reinforced by adult programs in the mass media, in industry, in medical and dental offices, in hospitals, and in every feasible milieu.

"By contrast, before the community laboratory program was launched, most cigarette control efforts were centred in the junior high school health education programs," Althafer said.

These efforts were ineffective because they received virtually no support in the "real" world outside the schoolroom, he added.

Highlights of the community laboratory activities in the schools included classroom demonstrations by specially selected young teachers in elementary schools, junior and senior high schools. The presentation featured a mannequin called "Smoking Sam," about the size of a 12-year-old boy.

Sam is equipped with two glass jar "lungs" which collect cigarette smoke drawn in by an aspirator bulb. As a background to their discussion of smoking problems, students can see the accumulation of condensates in Sam's "lungs." Over 140,000 students have taken part in these programs.

In another school activity, a coloring book was developed for kindergarten through fourth grade students. Based upon a skit by second graders, the book tells a story, and children draw their own impressions of the story, which stresses forest animals and fires rather than chronic disease.

Students from 11 Key Clubs were trained to conduct student-to-student presentations in elementary schools and junior high schools feeding into their own senior high school.

"Nicoteena" was the name given to hundreds of small dolls distributed to all elementary schools in the county. Nicoteena is constructed around a simple aspirator bulb, enabling the teacher to draw cigarette smoke through filter paper in a graphic demonstration of tars and other condensates left on the surface.

Two special teacher aids were distributed to city, county and parochial schools. One was a curriculum guide, color-keyed so the teacher could readily select teaching content by grade level and academic area. The other was a science teacher's kit consisting of experiments, color slides, overlays and other resources.

In the health professional field, a series of scientific meetings was aimed at physicians, dentists, psychologists, nurses and other health workers. Cigarette sales have been banned or curtailed in most hospitals in the county. Office signs reading "For Your Health's Sake and the Comfort of Others, No Smoking, Please" were placed in over 400 offices. Both the American Medical Association and the American Dental Association have developed their own versions of this sign.

A back view of Smoking Sam

"Quit smoking" groups were coordinated by a psychiatrist, and 600 pairs of Gough-Wentworth lung sections distributed for physicians' use in counselling patients.

In-service nursing education programs were presented at various hospitals, dealing with etiology, diagnosis, treatment and rehabilitation of cigarette-related chronic disorders such as cancer, cardiovascular disease and obstructive lung maladies.

Adult community programs have included effective exhibits displayed at the Southern California Exposition, which attracts 50,000 visitors annually, and at numerous fairs and shows.

Demonstrations and exhibits were presented at many major shopping centres, and pulmonary function tests were offered to the public to allow comparison of smokers' test results with accepted norms.

Industry interest in the anti-smoking drive has been strongly stimulated, beginning with an Environmental and Occupational Health Conference, stressing cigarette problems, and supported by the San Diego Chamber of Commerce and the county medical society.

A broad spectrum of activities was conducted in the mass media, featuring amateur and professional sports stars, and a regular newsletter. Two major television documentaries were filmed—the "Smoking Spiral" broadcast on National Educational Television, and the "National Smoking Test" shown on the Columbia Broadcasting System.

Among the mass communications devices produced and distributed in large quantities were attention-compelling automobile bumper stickers reading "Cigarettes are Bummers" and "Morticians Dig Smokers."

The community laboratory project has expended more than $850,000, but Althafer noted that "compared to other saturation campaigns like new commercial product promotions or political election campaigns, this is a relatively modest cost, and on a per capita basis the outlay for a five-year period does not even approach that for cigarette advertising in a single year."

He paid tribute to the essential role of physicians, dentists, nurses, psychologists and other health professionals, without whose support the program would "lack credibility and become steeped in moralizing".

Pacific States expand program

KUALA LUMPUR—The 19 Western Pacific states in the World Health Organization's region have agreed to expand their joint program to control drug dependence by including alcoholism.

Health officials of the member states, including the United States of America and the United Kingdom, met in Malaysia for the 25th annual meeting.

"While drug dependence at present affects relatively few . . . of the region's population," they concluded after discussion and reports, "it could become a more widespread and grievous problem in the future. . . .

"The problems created by excessive use of alcohol and tobacco are of great importance in this region."

The program is supervised by the WHO Office in Manila, whose specialists are assisted by consultants from many parts of the world, including physicians, pharmacologists, psychiatrists, behavioral scientists and public officials.

The plan includes epidemiological reporting; exchange of research findings dealing with prevention, treatment and rehabilitation; health education strategy; and professional training.

Training centre stresses alternative lifestyles

By TOM W. HILL

CORAL GABLES, FLA.—One sentence in a brochure of the National Drug Abuse Training Centre here, strikes the uninitiated as something of a cop-out:

No attempt is made to provide the trainee with any kind of clear and final solutions to any aspect of the drug problem.

But it means exactly what it says, according to Thomas J. Cahill, Jr., deputy coorinator of the centre.

"We don't have the answer to the 'drug abuse problem'. As far as I'm concerned, no one has the answer. But what we can do for our trainees is show them the various elements that go into what we perceive the phenomenon to be.

"We follow the school of thought that considers the drug addiction problem as really a *people* problem," he adds. "For the most part you're talking about people who have problems they cope with—in certain circumstances—by using drugs. Other people use different coping mechanisms—like eating too much or too little, working too hard or too little, smoking too much, or jogging too much.

"Drugs happen to be available and they're promoted. Since they're around, and are used as a coping mechanism, it's our view

Thomas Cahill, Jr.

drug abuse can best be combated by teaching people how to deal responsibly with situations of stress, anxiety, tension and so forth. There's tension and anxiety in everybody's life.

"You're not going to eliminate these anxieties. People have to cope with them. So the drug abuse problem really becomes one of value-setting. Drug abusers are basically people who have not learned to make the value judgments that would enable them to set values and opt for something different from the type of behavior they have. Sometimes they can be helped by just exposing them to other types of behavior."

Much of what Cahill and his colleagues teach trainees revolves around the concept that the person coping with problems through drugs or alcohol needs help to develop an alternative life style. It calls for more than conventional counselling.

"It's important for the counsellor to have an awareness of the needs of the person he's counselling and to be able to deal with those needs, either directly or by referral." Cahill told **The Journal**.

"A multitude of factors may be involved. If you, as a counsellor, can't be that person's lawyer, accountant, and bookkeeper, as well as therapist—you should know where he can get help in these areas. I'm not saying family backgrounds aren't important. But they may be only 20% of the problem."

A wide range of questions must be considered in counselling, many of them questions that used to be answered in absolute terms by priest, minister or rabbi says Cahill. But young people now are raising new questions and are disinclined to accept absolute answers.

The programs and sessions of the NDATC recognize this and stress there are no definitive answers, and that it is a mistake to counsel a youngster or an adult as if there were.

The centre, set up under the auspices of the National Institute on Drug Abuse, is part of the University of Miami's Applied Social Services Section and one of about half a dozen in different parts of the country. Training programs are conducted at the centre and in the field, in cooperation with Dade County's Comprehensive Drug Program, the university's School of Medicine, and the rehabilitative resources of numerous Dade County social agencies and drug treatment programs.

In some ways, the Coral Gables centre is unique. For one thing, it is in an area with a high proportion (about 50%) of people of Spanish-American background. This led to its being asked by the federal government to develop courses in Spanish for trainees from various Latin American countries. Several have been organized and attended by trainees from nearly a dozen of the republics of Latin America.

Some 8,000 people have taken courses in the centre in the four years since it was set up.

Trainees spend about 40% of their time in academic activities and 60% with patients in drug treatment programs. A trainee successfully completing any course receives a certificate of completion. If he is doing university work, he may earn from one to three undergraduate credits, for transfer through the School of Continuing Studies of the University of Miami.

Trainees include representatives from the Surgeon-General's office, officers and enlisted men from the U.S. Army, Air Force, and Marine Corps, privates from Turkey, captains from England, physicians from Southeast Asia, psychologists and social workers from South America—and nurses, counsellors, paraprofessionals, psychologists, sociologists, high school students and housewives from the immediate area.

"We like it that way," Cahill says. "In drug programs, all sorts of different people have to work together. One of their problems, in many cases, is that they *don't* work together. They're in a pecking order that can lead to all sorts of frustrations. You see it in drug programs—a sort of rivalry between the MD and the paraprofessional or the nurse, for instance. Who's going to run the group? Is the nurse going to do it? Or is the ex-addict?

"Considering the wide range of problems that any single drug abuser may have, we think it's a good idea for people with different qualifications to be trained together, so they can absorb some ideas about teamwork."

All the courses offered at the centre are subject to evaluation although a cutback in funding this past year has meant a reduction in evaluation programs.

"I regretted this," says Cahill, "because to me it was one of the most beneficial parts of the program. We still have *some* evaluation—an in-house system of pre- and post-training testing and later we send out a written form as a followup. I wouldn't defend it before a group of statisticians, but it's something.

"The real way to evaluate a training program, as far as I'm concerned, is in terms of services being delivered to people. Our ultimate aim is not what we do with the trainee on a test or examination. Rather, we need to ask if the trainee is able to go back to his or her community and provide services to people in a better, more effective fashion. That, to me, is the crux of everything."

Decriminalize pot: ASHA

FURTHER SUPPORT for the decriminalization of marijuana has now come from the American Social Health Association's Drug Abuse Task Force—West.

In a forthright position statement, the task force, which has been active for many years combating drug abuse in the western states, opposed use of criminal law against people who "despite the policy of discouragement" do smoke marijuana.

The 14-person task force concurred with conclusions of the National Commission on Marijuana and Drug Abuse that "neither the marijuana user nor the drug itself can be said to constitute a danger to public safety".

It also concurred with the Commission's recommendation to eliminate criminal penalties against the user.

Book Report

The following books have recently been acquired by the Addiction Research Foundation library in Toronto. These books are not for sale at the library, but general enquiries may be directed to The Library, 33 Russell Street, Toronto, Ont. M5S 2S1 (595-6144).

Students Speak on Drugs: The High School Student Project: Drug Abuse Council, Inc., Washington, 1974, 150p., $2.25.
Drug Education: Current Issues, Future Directions: Smart, Reginald G., and Fejer, Dianne, Addiction Research Foundation, Toronto, 1974, 112p.
A Guide to Addiction and its Treatment: Glatt, M. M. Medical and Technical Publishing Company, Ltd., Lancaster, 1974, 346p., $7.79.
Organization and Administration of Drug Abuse Treatment Programs: National and International: Cull, John G., and Hardy, Richard E. Charles C. Thomas, Publisher, Springfield, 1974, 342p., $15.75.
Drug Abuse and Drug Addiction: Rosenbaum, Max (ed.) Gordon and Breach Science Publishers, New York, 1973, 98p., $9.80.
The Marihuana Conviction: Bonnie, Richard J., and Whitehead, Charles H. University Press of Virginia, Charlottesville, 1974, 368p., $12.25. "A history of marihuana prohibition in the United States".
The Marijuana Farmers: Hemp Cults and Cultures: Frazier, Jack. Solar Age Press, New Orleans, 1974, 133p., $2.75.
America's Worst Problem: Alcohol: Reilly, Richard L. Liquori Publications, Liquori, 1974, 128p.
Executive Life-Styles: A Life Extension Institute Report on Alcohol, Sex and Health: Johnson, Harry J. Thomas Y. Crowell Company, New York, 1974, 221p., $6.81.
Drug Use, the Labor Market and Class Conflict: Helmer, John, and Vietorisz, Thomas. Drug Abuse Council, Inc., Washington, 1974, 44p., $1.25.
Recent Spread of Heroin Use in the United States: Unanswered Questions: Hunt. Leon Gibson. Drug Abuse Council, Inc., Washington, 1974, 29p., $1.25.

More 'mental education' less 'drug info', urged

JERUSALEM—Money must be channeled away from "drug education" programs and into "responsible forms of mental education," says Dr. Evert Dekker, sociologist and chief of the department of mental hygiene of Holland's Ministry of Public Health.

He participated in the Third International Symposium here on Drug Abuse, and discussed experience in his country with "The Education of Youth and Drug Abuse."

"A social mechanism that sees the 'drug problem' as an isolated one, threatening public health, is kept in the news artificially and approached weightily," he said.

"The selective attention results in a self-fulfilling prophecy—drug expectation.... Thus governments... feel obliged to avert the danger, to take preventive measures, to provide information....

"As it is now becoming clear that most information on drugs is ineffective, it should be possible to use the resources—money, time, manpower—for responsible forms of mental education."

Dr. Dekker, however, saw one advantage in "selective attention to drugs"—exposing the obvious "discrepancy" between the approach to illegal drugs on the one hand and to "other dangerous substances" such as alcohol, psychotropics, and tobacco on the other. He welcomed the consequent return to fashion of anti-alcohol information

"The worst form of drug education is the once-only, deterrent, unspecified provision of information on drugs pure and simple, in isolation from other preventive measures, and aimed at abstinence," he said.

Reporting on two new research projects dealing with drug education in his country, he said it took five to 10 years before objective research findings in mass communications and group dynamics could be used.

This delay was caused by "underdevelopment of health education in general" and the "emotional, ethical approach to the phenomenon which made rational use of the knowledge impossible," he suggested.

"The complexity of the phenomenon has been underestimated," he said. "Relations between policy, police action and mass media, on the one hand, and drug use, have been ignored. The totality of government policy, mass media, socioeconomic factors and youth culture determines the attitude towards drugs. Information must be based on attitudes and selective knowledge and thus make allowance for the totality of background factors.... Among young people the factors of age, parents and nonconformism have been proven to play decisive roles....

"Today in the Netherlands, children from 12 to 16 years are well acquainted with alcohol, 75% of them having drunk it... but the same group knows little about illegal drugs and uses them very moderately: 6% have used them on some occasion.

"This means that drug education, as a part of mental health education, must be given to children within a frame of reference of *the* most widespread substance, alcohol. As this use is 'learned' in social settings, especially the family, education should start with that setting."

'Impact' for smokers

MONTREAL—One of every five hard-core cigarette smokers can be salvaged with one 45-minute treatment of "impact therapy", says the New York psychiatrist who devised the technique.

"Every habitual smoker motivated to stop should be exposed to this treatment," Dr. Herbert Spiegel told **The Journal**.

Dr. Spiegel is associate professor of psychiatry, College of Physicians and Surgeons, Columbia University. He was interviewed at a meeting here of the Society for Clinical and Experimental Hypnosis.

Dr. Spiegel's therapy—an hypnotic relaxation procedure—puts the emphais on what the smoker is *for* rather than what he or she is *against*.

Having brought the patient into a state of meditation through hypnotic relaxation technique, the psychiatrist asks his patient to concentrate on three critical points—the protection of the body, the patient's need of his body if he is to live, and the respect to which the body is entitled.

- For your body, not for you, your smoking is a poison.
- You need your body to live.
- You owe your body this respect and protection.

The procedure includes the taking of brief clinical and smoking histories, a test for hypnotizability and some instruction in self-hypnosis.

When the patient has learned to enter the receptive state, the concepts mentioned are repeated and elaborated upon. The main emphasis is on an overtly positive reinforcement. Negative reinforcement is only inferred.

"The use of hypnosis is by no means primary," Dr. Spiegel said. "It is ancillary in that it creates an atmosphere of attention.

But why one treatment? If one is good, would not two be better?

"No," said Dr. Spiegel. "When the patient comes in for a session, it is understood there will not be a second session. There is a momentum here. You can get the optimal impact."

Dr. Spiegel's research also focuses on smokers apparently resistant to all "cure" methods, including his own.

With data on about 1,000 people, he is trying to establish criteria to identify those who may yet be salvaged and how they might be approached.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

American Group Psychotherapy Association, Inc. 19th Annual Institute and 32nd Annual Conference—Feb. 4-8. San Antonio, Texas. Information: American Group Psychotherapy Association, Inc., 1865 Broadway, 12th Floor, N.Y. 10023.

Southeastern Conference on Drug Use/Abuse—Intervention/Prevention—Feb. 20-22, Atlanta, Georgia. Information: Dr. T. J. Gleaton, P. O. Box 313, Georgia State University, Atlanta, Ga. 30303.

31st International Congress on Alcoholism and Drug Dependence—Feb. 23-28, Bangkok. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Recent Advances in the Management of Alcoholism and Drug Addiction—March 1, Toronto, Ont. Information: The Director, Division of Post-graduate Medical Education, University of Toronto, Toronto, Ont. M5S 1A8.

American Orthopsychiatric Association—Fourth Annual Institute and 52nd Annual Meeting—March 21-25, Washington, D.C. Information: American Orthopsychiatric Association, 1775 Broadway, N.Y. 10019.

59th Annual Meeting of the Federation of American Societies for Experimental Biology—April 13-18, Atlantic City, New Jersey. Information: Mrs. T. C. Heatwole, Director, Public Information, 5110 W. Franklin St., Richmond, Virginia 23226.

Postgraduate Day on Clinical Pharmacology—Antimicrobial Drugs—April 5, Toronto, Ont. Information: The Director, Division of Postgraduate Medical Education, Faculty of Medicine, Medical Sciences Building, University of Toronto, Toronto, Ont. M5S 1A8.

National Drug Abuse Conference—April 4-7, New Orleans. Information: Mr. V. Shortly, Director, Desire Narcotic Rehabilitation Center, 3307 Desire Parkway, New Orleans, Louisiana 70126.

National Alcoholism Forum—Annual Conference of the National Council on Alcoholism—April 27-May 2, Milwaukee, Wisconsin. Information: George C. Dimas, Executive Director, National Council on Alcoholism, 2 Park Avenue, N.Y. 10016.

Sixth Annual Medical Scientific Conference of the National Council on Alcoholism—April 28-29, Milwaukee, Wisconsin. Information: George C. Dimas, Executive Director, National Council on Alcoholism, 2 Park Avenue, N.Y. 10016.

Institute on Crime, Justice and Heroin—May 19-June 3, London, England. Information: Dr. A. S. Trebach, Centre for the Administration of Justice, The American University, Washington, D.C. 20016.

10th Annual Conference of the Association of Halfway House Alcoholism Programs of North America, Incorporated—June 8-11, Hot Springs, Arkansas. Information: Jack Shea, Conference Coordinator, Association Office, 786 E. Seventh St., St. Paul, Minnesota 55106.

21st International Institute on the Prevention and Treatment of Alcoholism—June 9-15, Helsinki, Finland. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Sixth International Congress of Pharmacology—July 20-25, Helsinki, Finland. Information: Secretariat, Sixth International Congress of Pharmacology, Siltavuorenpenger 10, SF-00170 Helsinki 17, Finland.

Third International Conference on Drug Abuse—Sept. 1-5, London, England. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

First National Conference on Occupational Alcoholism and Drug Abuse—Nov. 17-20, Ottawa, Ont. Jointly sponsored by Humber College and Addiction Research Foundation. Information: Jim Simon, A.R.F., West Toronto Branch, 4143 Dundas St. W., Toronto, Ontario M8X 1X2.

International Conference on Alcoholism and Drug Dependence—Oct. 26-Nov. 1, Sao Paulo, Brazil. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Positions Available

In Scotland

Physicians demand government action

A FIVE-POINT statement of demand has been issued to the Secretary of State for Scotland by a group of prominent physicians, psychiatrists and social workers in the alcoholism field.

The step follows the presentation last summer to the Secretary of a statement of concern deploring the lack of facilities for dealing appropriately with drunken offenders in Scotland. (**The Journal**, October, 1974).

The 39 signatories claim, however, that the first statement was unsuccessful in stimulating the government into reviewing the situation and introducing appropriate alternative measures.

"This is reflected in the continuing non-appearance of the anticipated Government Circular on community services for alcoholics.

The new statement demands that the Circular be issued immediately in draft form; that the finalized version be issued incorporating additions and amendments with a minimum delay; that an advisory committee on alcoholism be set up (as has been done in England and Wales); that the committee should have sufficient government resources to promote services in accordance with guidelines and recommendations; and that procedures used in the legal system for dealing with drunkenness offenders should be urgently reviewed.

In Maritimes

Illicit drugs behind increasing violence

By JOHN CARROLL

MONCTON—The recent kidnapping and murder of two policemen in this Maritime city is part of a larger picture of increased violence here caused by illicit drugs.

This is the opinion of Superintendent C. A. J. J. Philion, the officer commanding the Moncton Detachment of the RCMP.

In the past year, this community of 58,000 people has seen two gangland murders, a wounding and, most recently, the kidnap-murder of the policemen.

Illicit drugs underly the violence, according to Supt. Philion. And federal penitentiary release practices are compounding the problem, he charged.

Supt. Philion was speaking shortly after the bodies of the Moncton policemen were found in a shallow grave 15 miles northeast of the city.

He said drug-related crime had prompted him to request additional men and equipment prior to the police murders. In the last couple of years Moncton has suffered a spate of armed robberies.

"Most of our major crimes such as armed robberies . . . are involving drugs. We feel that robberies are being made for payment of drugs and often under the influence of drugs."

Late last year, local police and RCMP seized 70 pounds of hashish, with an estimated street value of $30,000, and a quantity of the restricted drug Phencyclidine (PCP). Although only 1¼ pounds of PCP was seized, police believe an additional dozen pounds were distributed from Moncton.

Supt. Philion said police authorites believe money realized from robberies "... is used to pay for shipments of drugs coming into the city" for trafficking purposes.

Increasingly efficient policing activities in major centres are forcing suppliers of illicit drugs to establish delivery in smaller centres, with a re-routing of the supplies back to the areas of large drug-using populations.

Although trafficking in Moncton has been in such so-called soft drugs as marijuana and hashish, with some LSD and amphetamines, Supt. Philion voiced concern that heroin may take hold.

Moncton is only 30 miles from the Maritime Federal Penitentiary at Dorchester, New Brunswick, and many inmates are paroled or released into the local area.

"We are concerned . . . that parolees from Western Canada who have been using heroin are being paroled in this area. We feel that in the long run (this) may create a market for heroin . . . a situation that is non-existent in the present."

Supt. Philion said although there is little evidence of ties between local traffickers and organized crime "... we have noticed an increased communication between local dealers from other major cities . . . Montreal, Toronto and Vancouver."

In addition, more local criminals are carrying handguns and restricted weapons.

Increased trafficking, robberies, drugstore break-ins, and an emerging pattern of dealers using east coast points of entry for drug-running, combine to portray a Maritimes being brought rudely to face one of the less-pleasant aspects of modern life.

But, if criminals can turn to a small city such as Moncton to maintain the illicit drug traffic, so can the law authorities use this geographically well-located city to combat such activities.

As Supt. Philion said: "We need more personnel and equipment to curb the situation. I'm thinking here of specialized units for a specific type of work. We have already taken steps to form specialized units, hopefully to work out of Moncton."

Treatment results poor, global review shows

By LYNN PAYER

STRASBOURG, FRANCE—Evaluative studies of the treatment of drug dependent persons, when they exist, show very poor results no matter what the therapy, the 11th Conference of Directors of Criminological Research Institutes was told here.

Only about 15% of drug-dependent persons, delinquent or not, can be considered drug-free two or three years after discharge from either in-patient or out-patient therapy, said Dr. Helmut Remschmidt, a professor of psychiatry at University of Marburg, West Germany.

"Even in these cases it is not sure if this is due to therapy or to some other (probably unknown) reasons."

In a global review of various treatment methods, Dr. Remschmidt noted that the failure of traditional forms of treatment has led to many new experiments, such as self-help groups, therapeutic communities, contact and consultation centres, relaxation and meditation techniques, and therapeutic excursions.

For most of these experiments, he said, evaluative studies do not exist or are not known.

"It is not possible to decide which methods of therapy are most efficient. But there is a lot of empirical evidence that punctual and fragmentary experiments in therapy, which are not integrated into an overlapping concept (therapeutic chain), work worst."

In his strong plea for a multi-disciplinary approach to therapy, Dr. Remschmidt admitted that while the idea of such an approach has been accepted for some time, "a smooth and fruitful cooperation does not always exist".

This may be because of communications problems among members of the various disciplines due to different modes of thinking and different linguistic concepts, he said.

It may also be due to disputes of competence: "While medical competence is unquestioned for the phase of withdrawal and detoxification, members of other disciplines always point out that these two steps are only the basis for further therapeutic measures which no longer necessarily fall into the doctor's competence."

Finally institutions may block a multi-disciplinary approach by barring the transfer of drug misusers from one institution to another, he noted.

The greatest barrier for a therapy, however, said Dr. Remschmidt, is that "there is too little reliable knowledge about the true causes of drug dependence."

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Alcohol mathematics

Lopsided equation

WINNIPEG—Alcoholism has become such a serious problem in Canada that for every alcoholic who manages to overcome his problem, two more confirmed alcoholics emerge to take his place, says R. M. Anthony, chairman of the Albert Alcoholism and Drug Abuse Commission.

Mr. Anthony urged participants in the Canadian Council of Christians and Jews seminar on chemical abuse to support more restrictive liquor laws.

But those who give such support, Mr. Anthony warned, will be "marked by the media, scorned by the brewing and distilling industry and bruised by the populace who do not understand."

Mr. Anthony said legislative controls are needed to:

- Limit future development of off-sales outlets and commercial drinking establishments.
- Rigidly enforce controls against liquor consumption by those under age 18.
- Prohibit consumption at sporting events and other public places and events.
- Curtail liquor advertising.
- Prevent the further lowering of the legal drinking age.
- Eliminate those beer parlors that are little more than "watering troughs and pig wallows".

The Alberta expert said provincial governments "fell under the axe" of the press and pressure from the brewing and distilling industries when they lowered the legal drinking age to 18 years.

"Happy hours", airlines "pushing" drinks on travellers, the lowered drinking age, and legislation permitting liquor sales at sporting events, are all signs of continuing pressure being applied by the industry,

Richard Anthony

said Mr. Anthony. And the media are on the side of the pushers.

He said Canada stood ninth in world liquor consumption in 1967 according to a survey by the World Health Organization, and came first in per capita consumption of distilled hard liquor.

"Among the top 10 consuming countries in the world, Canada rates top in percentage of distilled spirits consumed, with 36% as compared with France and its 13%, and Italy, which has 12.6%," he said.

The commission chairman said the study showed the cost of alcohol has dropped steadily compared with average personal disposable income.

Brewers and distilling companies, faced with zero population growth in Canada, are finding it necessary to find new customers among non-drinkers and to convince those who are already consumers to drink even more each year.

Cannabis hearings intensify as Canadian TV zooms in

By BRYNE CARRUTHERS

OTTAWA—Despite a warning from Health Minister Marc Lalonde not to duplicate the work of the LeDain Commission, the Senate committee on legal and constitutional affairs has dived headlong into its consideration of Mr. Lalonde's bill to modify cannabis laws in Canada.

Public interest in the cannabis issue is already on the upswing.

And it should grow even more now the Senate has set a Parliamentary precedent by allowing television cameras into the Senate committee while it considers submissions relating to the cannabis bill.

The CBC television cameras were scheduled to start rolling early this month, after the full Senate finally decided to allow the experiment for this bill alone. It was only after a full Senate debate, though, during which some Senators wondered aloud whether the television cameras might turn the committee considerations into a circus, releasing the "ham" in many of the honorable Senators, and perhaps drawing out the parliamentary consideration of the Bill even further.

It was this worry about further delays in passing the bill during this session that was reportedly behind Health Minister Lalonde's warning that the Senate committee not duplicate the LeDain Commission's work.

The Senate Committee seems to have decided to take its responsibilities seriously. A large number of witnesses were scheduled for the first month of the hearings, which began with the RCMP and the Canadian Medical Association (and a week of considering the television question).

The CMA stirred up a cloud of controversy on both sides of the spectrum in calling for decriminalizing the crime of cannabis simple possession, while not actually legalizing the drug. A group of doctors from Nova Scotia, Prince Edward Island, Toronto, and British Columbia almost immediately criticized the CMA stance as being too lenient in light of evidence that cannabis is physically harmful.

And, in a submission to the committee, Prince Edward Island called for a delay in the implementation of the proposed less-stringent cannabis possession penalties until a major educational program could be launched across Canada to publicize the harmful effects of cannabis.

P.E.I.'s proposals, made by Education Minister Bennett Campbell in a written submission, also suggested that persons convicted for cannabis possession and other related offences should be placed on a special form of educational probation, in addition to other punishment. During the probation, they would be required to read about the harmful effects of cannabis and prove to a parole officer's satisfaction that they were familiar with the problems of cannabis use.

Meanwhile, the RCMP argued before the Senate committee that they needed possession of cannabis to continue being a criminal offence so that police could control use of the drug. The RCMP have made a similar argument in the past about needing a possession penalty for other hallucinogenic drugs, specifically amphetamines ("speed").

U.S. ALCOHOLIC NUMBERS GAME

RALEIGH, N.C.—How many alcoholics are there in America? There is no question that the official estimate of nine million has no real basis, says a leading researcher on alcoholism.

"Asking how many alcoholics there are in this country is like asking how many hypertensives there are or how many diabetics there are. Nobody knows. Certainly there are a lot," said Dr. Donald Goodwin, head of the Washington University Addiction Research Center, St. Louis.

He added: "It is sort of amusing to me that when the Federal Government started spending money on alcoholism about five or six years ago, the figure was five or six million alcoholics. During that five years it has gone up to nine million.

"I don't know where we are going to stop. Somebody even dropped a figure recently of 25 million!"

DEA studies U.S. pot laws

THE POSSIBILITY of relaxing controls on cannabis in the U.S. is being studied by the Drug Enforcement Administration (DEA).

The hearings are in response to a 1972 petition of the National Association for the Reform of Marijuana Laws (NORML) and the American Public Health Association (APHA).

Cannabis is, at present, among the most strictly regulated of controlled substances listed in Schedule I, the group not available by prescription.

No therapeutic uses are recognized in the U.S., although Dr. Joel Forte testified that cannabis may be useful in treatment of glaucoma and asthma.

NORML's attorney, Peter Meyers, says the goal of his group is to make cannabis available by prescription. NORML also seeks Schedule 5 listing for cannabis leaves, which contain less THC than some other parts of the plant, or even removal of the leaves from control. This would allow the product to be sold without restrictions.

The petition requests removal of all controls on cannabis by eliminating it from the list of controlled substances or alternatively putting it in Schedule 5, according to DEA's deputy chief counsel, Robert J. Rosthal.

Several issues involved in the case were presented at hearings in late January before Judge Louis Parker, who will make recommendations to DEA Administrator John Bartels. Bartels' final decision is expected about May.

One question at the hearings is whether the U.S. may, in fact, shift cannabis to a lower schedule of control under international treaty regulating the substance signed by 104 nations.

The U.S. signed the Single Convention on Narcotic Drugs without reservations unlike other countries, Rosthal says. India, for example, signed with reservations because the plant is used medicinally there.

Krever Report

ARF's strengths, weaknesses pinpointed

By GARY SEIDLER

TORONTO — The Addiction Research Foundation of Ontario is "an essential institution with a reservoir of strength", which must now dedicate itself to "eradicating the weaknesses which so impair its competence".

So concludes the report of a two-year inquiry into the organization and operation of the 25-year-old agency of the Province of Ontario.

The inquiry, conducted by Horace Krever, a University of Toronto law professor, was commissioned by the Members of the Foundation (the ARF's board of directors) following public criticism of the organization's administrative practices.

The 40-page report, compiled largely on the basis of 200 interviews with past and present ARF staff, heaps considerable praise on the Foundation's "commendable work." It places much worth on the research effort which has earned the organization a revered international reputation.

At the same time, Krever surprised at least some critics who had anticipated a "whitewash," with an often harsh critique of the foundation, its executive director and several senior personnel.

Despite several acknowledged handicaps—essentially based on the confidential nature of the report which inevitably resulted in an "impressionistic" report—Krever managed to make six major recommendations, which, if implemented, would dramatically change the foundation's overall look and operation.

The most important recommendation, according to Krever, calls for outside consultants to study and (potentially) suggest changes in the foundation's management methods, structure, organization and personnel.

Krever, also a labor arbitrator, urged the foundation board to ask the province to make changes in legislation which would permit ARF employees to gain bargaining rights.

"It is too late in the day for an essentially paternalistic employee grievance mechanism.

"Employee dissatisfaction and distrust is so widespread it is unlikely the situation can be

(see—ARF—page 2)

Hare Krishna cures—page 5

... INSIDE

Krever Report

ARF strengths, weaknesses pinpointed

(continued from page 1)

improved by the unilateral action of the foundation) board of senior management," Krever wrote.

Concluding that the ARF had lacked direction and purpose in its evolution, Krever recommended that the foundation board determine a clear statement of goals, policies and priorities.

Krever suggested that the foundation had not taken full advantage of its independence and its executive director, H. David Archibald has tended to be too sensitive to what is anticipated "the government" may be thinking.

Krever left no question as to where he considered the foundation's strength and major priority —research.

He suggested it was unfortunate the ARF had diverted from pursuing its prime course as a research institution by providing treatment on a mass scale.

. . . "Relative to other purposes of the foundation, too small a percentage of the budget has been allocated to research."

Of the foundation's three main function areas—research, education and treatment—research is the only area which could not be conducted as ably elsewhere.

"The other functions should be transferred to other agencies, except to the extent that they are directly related or incidental to the research function."

Of the foundation's education work, Krever spoke of the strong sense of difficulty in evaluating the success of activities.

He was unconvinced of any special competance in the foundation's educational work "that is not exceeded elsewhere in society."

To engage in treatment beyond that incidental to applied research or pilot projects is to create expectations which cannot be met and, as a result, hostility, Krever noted.

With specific reference to the foundation's regional programs, (there are 40 A.R.F. offices scattered throughout Ontario), Krever suggested that much of the treatment work should more appropriately be delivered through provincial district health councils.

Subsequently, he recommended that the Foundation board and the Minister of Health re-examine the foundation 'Act' to clarify which responsibilities should fall within the jurisdiction of the health care or community and social development system of district health councils or regional governments.

Krever observed that the foundation's clinical institute, a 100-bed teaching hospital, is really a seperate institution from the Foundation.

The clinical institute is financed seperately through the Ontario Hospital Services Commission).

There is unnecessary and costly duplication, Krever charged.

Krever pointed to two practical consequences of this "seperateness" of institutions.

First, as a public hospital, the clinical institute cannot be independent of supervision and policies of the Ontario Ministry of Health. Second, the financing formula of the clinical institute as a public hospital has the effect of encouraging the filling of the hospital for treatment purposes.

Krever suggested that beds for research projects are unavailable and urged a total integration between the clinical institute and the foundation research program.

Specifically, he recommended an end to the clinical institute's status as an independent public hospital and urged the transfer of clinical research facilities and demonstration models to the Foundation's research division.

Krever had strong words for the Members of the Foundation whom he portrayed as a group of individuals who, rather than playing any discernible role in decision making or policy formulation, simply endorsed policies as presented by the foundation's executive director, David Archibald.

While the "Members" are appointed by the Lieutenant Governor in Council, Krever said recent appointments resulted from lists of names suggested by Archibald.

In his criticism of the board, Krever spoke of "their apparent incredulity when an avalanche of criticism and condemnation descended on the foundation."

He said board members were unaware of the weaknesses in the foundation but they demonstrated good faith by readily agreeing at the beginning of his inquiry to release the report publicly.

Krever recommended that in future, board members be appointed not from names suggested by the foundation but from an examination of sources "that would produce persons who will devote the time and concern necessary to discharge the duty of making policy for the foundation."

In providing an historical sketch of the foundation, Krever said the most telling feature of the organization's problems is linked to its rate of growth, in terms of staff and budget.

In 1953, there were 36 people employed in Toronto. By 1969, 550 employees were located throughout the province in eight regional headquarters and 30 offices. By 1973, more than 800 employees were employed in 42 provincial offices.

The ARF's first budget was less than $50,000. The 1973-74 budget was $4.4 million for the Clinical Institute and approximately $9 million for the foundation.

"From a very small undertaking in which Mr. Archibald became a beloved leader of, and a sort of father-figure for, the few but loyal employees, the foundation rapidly became a huge and sprawling enterprise whose organization was not ideally suited to its size and rate of growth.

"Particularly with respect to its relation with employees, it remained paternalistic in concept, resulting, unfortunately, in wholesale dissatisfaction among employees, especially in Toronto," wrote Krever.

Krever dealt at length with the way in which the foundation's executive director was presented to his staff.

". . . Substituting for the natural goodwill that arises out of a daily and visible relationship between executives and staff, there was devised, presumably by Archibald's assistants, an almost artificial or manufactured cult-type image of the leader."

While acknowledging that "a great debt is owed by the people of Ontario to H. David Archibald," for his "great contribution", Krever suggested that a change in the style and leadership necessary to take the foundation to the next step of its evolution may be in order.

Krever then focussed his attention on the ARF's "senior management team," a group of six individuals "with high skills in their particular disciplines."

However, he felt the use of the "team concept" to make decisions proved unsatisfying and unsatisfactory.

Krever said the foundation's administrative division is large and probably the source of most of the Foundation's recent problems.

The administrative area, he said, appears too often to have been the master rather than the servant of the organization's operation.

Krever suggested this may be due to the "superior competance" of the ARF's director of administration, Henry Schankula.

In any event, Krever questioned the wisdom of placing the foundation's educational departments within the administrative division.

Krever said the rate of growth and the rate of staff turnover had the result of bringing about promotion of many young and inexperienced persons to supervisory positions.

Another phenomenon referred to revolved around what Krever called an apparent practice of downgrading professionals by non-professionals.

Krever said some foundation research scientists held a justifiable belief that there is lack of respect, if not distrust, in the foundation for professionals and an enhanced status for the amateur.

"All that I have seen and heard convinces me that, over the year,. personnel practices by supervisory persons have been conducted in an amateur fashion."

Report initially satisfying

'Not a whitewash': critics

By GARY SEIDLER

HORACE KREVER, author of a report which pinpoints weaknesses at the Addiction Research Foundation of Ontario, may be surprised to learn that, contrary to his stated expectations, his critique has gained at least some initial satisfaction.

Following the report's release, **The Journal** interviewed the foundation's two leading critics—Paul Biringer, a University of Toronto engineering professor, and Andrew Malcolm, a psychiatrist fired by the ARF in 1972.

Paul Biringer, described in the Krever report as a "sensitive man" who has "devoted countless hours to the role of informal ombudsman to employees of the foundation", said there are certain signs of improvement at ARF.

"There has been a gradual building of staff confidence and morale as a consequence of ARF's new 'no-firing' policy which has allowed people to open up," he said.

Biringer became involved in the foundation's affairs after his wife, a psychologist, was one of several persons fired from one of the ARF's Toronto branch offices.

The report explains that: "To this day, he (Biringer) has informants in the foundation who advise him of developments, occurrences and decisions about which even senior supervisory personnel are not yet informed."

Krever went on to say he was completely satisfied that Biringer means no harm to the foundation and, on the contrary, believes a strong foundation is necessary.

Krever also suggested an invitation to Biringer to become a member of the board should be considered.

Biringer told The **Journal** it is premature to discuss this topic.

As for the report itself, Biringer agreed it was certainly not the "whitewash" which had been feared. He suggested some, but not all, of his concerns had been addressed.

"I would have preferred to see more factual information included in the report," said Biringer, "but I realize the handicaps faced by Krever with respect to confidentiality of information."

Biringer said he would like to see the implementation of some, if not all, of the report's formal recommendations.

With reference to Krever's recommendation that collective bargaining be introduced in the ARF, Biringer agreed that evolvement of employee groups is a step to potentially drastically improve employer-employee relations.

"If this recommendation was implemented, people would not need to go outside ARF with their complaints," he remarked.

Biringer agreed with Krever's assessment that his most important recommendation involved the appointment of management consultants to review foundation operational methods and personnel.

Dependent on how this is acted upon, "this is *potentially* the most important recommendation in the report," said Biringer.

He also agreed that the foundation's procedure in nominating new members to the board needed overhauling.

Andrew Malcolm, dismissed by the foundation in 1972 under circumstances described by Krever as "characterizing the use of bad (managerial) judgment", told **The Journal** he felt "completely vindicated . . . now that all our criticisms have been acknowledged".

In expressing interim satisfaction, Malcolm said of the Krever report: "As a beginning, it's good."

"It was a completely necessary and important report written by an undoubtedly honest, perceptive man.

"The general malaise portrayed by Krever is extremely important as is his discovery of administrative weakness."

While he strongly agreed with several of Krever's recommendations, Malcolm did not agree that the ARF should divest itself of either its treatment or educational role.

A strong Addiction Research Foundation with strong research, treatment, and education components is essential, said Malcolm.

Malcolm said he looked forward to the retention of an outside consulting firm to step in and recommend further organizational changes.

Of the Foundation's board of directors, Malcolm said the "Ontario government should not allow the board to continue in its characteristically weak fashion."

Malcolm felt the foundation's executive director "richly deserved" the criticism he received in the Krever report . . . "his competence was exceeded by a growing organization".

Malcolm further stated that the foundation's clinical institute has been "a disaster area since day one" and that the organization's regional program and staff have been "maltreated for some time".

Malcolm also had harsh words for the foundation's board of directors.

"Board members should feel a certain degree of anguish and want to make amends for their weakness."

He suggested that four recent appointments to the board be re-examined in light of the recommendations in the Krever report.

Malcolm was particularly pleased Krever had acknowledged "our recommendation" respecting the introduction of collective bargaining.

A major opportunity ARF board chairman

THE "KREVER Report" provides the Addiction Research Foundation with an opportunity to continue focussing on several problem areas, according to Lawrence C. Bonnycastle, chairman of the Members of the Foundation (the ARF's board of directors).

"I am delighted to have the report in that it gives us an opportunity to vigorously pursue our course," Bonnycastle told **The Journal**.

He said the value of the report is in the way it has "spotlighted problems which the ARF is facing and regarding which the foundation has spent a great deal of time in determining its goals and (priority) policies".

Bonnycastle said the report was somewhat unsatisfactory because of its "impressionistic" nature, a point Professor Horace Krever acknowledged in his report.

"Some comments," said Bonnycastle, "were too harsh and unfortunate". He regretted remarks made about the foundation's executive director, H. David Archibald, and made it clear he did not support the views expressed by Krever in this regard.

Bonnycastle promised the board would move quickly to consider the many suggestions made in the report . . . "many of which have been under discussion for some time".

And he stressed the ARF had not been "sitting on the fence" throughout the 22 months of the Krever inquiry.

The question of staff morale, said Bonnycastle, has been under review and steps have been taken to improve communication and employee morale.

Similarly, he said the ARF has and is in the process of establishing priorities both internally and in cooperation with the Ontario Ministry of Health.

With respect to Krever's recommendation that the foundation's clinical institute be merged with the organization's research division, Bonnycastle said closer integration between the two areas is being pursued and there have already been substantial gains.

The chairman said research continues to be a top priority within the foundation but because of the breadth of its responsibilities and the necessity of extending the results of its research, many other ARF activities are essential.

Bonnycastle rejected Krever's conclusion that the foundation's board had been ineffective. Similarly, he rejected Krever's notion that the board was somewhat of a rubber-stamping operation for the foundation's executive director.

"The board has participated in a broad way in foundation affairs," Bonnycastle stressed.

—SEIDLER

Animal experimentation indicates

Marijuana produces brain damage

By MILAN KORCOK

PERMANENT IMPAIRMENT to the mental processes of experimental animals subjected to prolonged marijuana use has been reported in a series of studies at the Addiction Research Foundation of Ontario.

At a meeting of the Ontario Psychiatric Association, Dr. Harold Kalant professor of pharmacology, University of Toronto, and associate research director, ARF, said the observed impairment—to learning function and motor skills—resulted from a direct toxic effect of the drug on the brain cells and could not be attributed to residual intoxication.

The dose, sufficient to produce marked intoxication for several hours a day over a six-month period, would have to be considered heavy exposure, and though one must be careful in transporting animal evidence too literally to the human environment, this series of studies did seem to provide "a reasonable model for heavy drug use in humans," said Dr. Kalant.

Slowing and interruption of mental processes, difficulty with abstract thought, loss of memory, and impairment of learning have long been recognized as clinical manifestations of alcoholism. But there has been much debate as to whether this was due primarily to the direct toxic effect of alcohol or to the malnutrition, head injury, hypoxia, and other drug use which often accompanies the alcoholic life style.

An analogous debate has raged about the various clinical descriptions reported among marijuana users.

Said Dr. Kalant: "Cannabis users . . . are often multiple drug users, and despite their middle or upper class origins, they often choose a life style in which malnutrition, infection and other factors confound the interpretation of drug effects."

Consequently, it is important to determine whether the drug alone is capable of producing permanent damage. And that is what the present series of experiments appears to have shown, asserts Kalant.

The experiments sought to determine and quantify degrees of functional impairment among animals during acute administration of marijuana and alcohol, subacute intoxication, and at various times after the periods of intoxication.

In the acute series, animals were trained to perform certain tasks in a maze. One group was treated with cannabis extract (10 mg/kg) administered by stomach tube one hour prior to testing. The other group was treated with an equal volume of a placebo—olive oil. Within two hours the rats were tested. They were then retested three days later.

The rats given marijuana committed significantly more errors than the control group, reported Dr. Kalant.

In another series, groups of rats were given the marijuana extract for 14 days—undergoing training and testing at certain intervals.

After six days, the marijuana-treated animals became very irritable, they showed little interest in the maze problems, moved very slowly, became aggressive, and their test scores showed many more errors and deviations than the control groups.

One interesting aspect of the findings among these groups was that tolerance did not seem to develop to the impairing effects of marijuana, it did develop—after only seven days of treatment—to the anorexic effects of the drug.

This confirms suspicions that tolerance to any particular drug develops not wholesale, but only to certain characteristics of that drug, said Kalant.

In the chronic series of tests, animals received one standard dose of cannabis extract daily for 30 days, another group for 60 days, and another for 90 days.

The animals were then withdrawn from cannabis use for two weeks after which they underwent training in the maze and then were tested.

Although there appeared to be more errors as the rats grew older, there was no real variance between the control groups and the treated animals, said Dr. Kalant.

However, when groups of animals were subjected to six months at doses of 20 mg THC/kg of body weight, distinct differences in testing performance were noted. At this point, animals treated with alcohol were also entered into the experiment.

The alcohol-treated animals were given 2 g/kg at first, increasing to 6 g/kg over two weeks.

During the six months, said Dr. Kalant, the alcohol-treated animals grew more poorly than either the marijuana group or the controls. The latter two groups grew well despite the fact the marijuana group was kept in an almost constant state of intoxication.

After six months all treatment was stopped, the animals were allowed to recover for one month, and they subsequently underwent training and testing.

Errors among the marijuana and the alcohol groups were significantly higher than the drug-free controls, said Dr. Kalant. Similar results were concluded when some animals underwent the learning of a motor skill—maneuvering on a moving belt apparatus.

The animals were then left for two months without any training and were retested, with the marijuana and alcohol groups still showing significantly higher impairment levels than the controls. Though the marijuana is likely to stay in fat deposits for some time, the residual level by the end of the month-long resting periods would be so low that intoxication could be ruled out as an explanation for the learning impairment, said Kalant.

"We have speculated that the observed impairment is a direct toxic effect which would increase the natural attrition rate of brain cells, i.e. an acceleration of the natural aging process."

This suggests the impairment to both cognitive learning and motor skills caused by long exposure to cannabis, and alcohol, is permanent.

A key question in this type of work, said Dr. Kalant, is the connection between learning deficit and organic brain damage.

"It is well known that many organic brain damage syndromes are recognizable first as behavioural impairment before organic damage becomes apparent. At this stage, the damage is often still reversible."

The emphasis in these series, said Dr. Kalant, has been to define brain damage in terms of functional impairment instead of in terms of cellular damage.

The necessity of treating animals for six months before getting to this stage of impairment is not surprising, he said, since alcoholics do not exhibit symptoms of organic damage until after five or ten years of heavy drug use.

This is exactly what would be expected if the mechanism of damage really is a slight increase in the rate of attrition of brain cells with age, as the present experiments indicate.

Jellinek award winner concludes:

Alcoholism 'runs in the family'

By ASHLEY McCONNELL

"THERE IS sufficient reason now to believe that in very severe alcoholics there is a predisposition which is biological and inherited," according to Dr Donald Goodwin, of Washington University, St Louis.

Dr Goodwin was one of two winners in 1974 of the E.M. Jellinek Memorial Award for outstanding contribution to the study of alcohol problems.

His research into this aspect of alcoholism includes a collaborative study with Danish psychiatrists on alcoholism among adopted men and women in Denmark, and a St Louis survey of alcoholism in siblings and half-siblings and from which he is now extrapolating preliminary data.

Dr Goodwin, director of the Washington University Addiction Research Center and a professor of psychiatry in the medical school, said the evidence shows alcoholism "runs so strongly in families that I find it hard to believe that in all cases of alcoholism just the family exposure would be sufficient to explain it.

"It just does not make sense to me. If I had no other evidence than that I would strongly suspect it, because alcoholism runs more strongly in families than almost anything else."

The collaborative Danish study, now in the fourth of a planned six years, and probably to be extended beyond that, takes Dr Goodwin to Copenhagen three times a year.

Information is collected by the Danes and translated into English before being sent to St Louis for data analysis.

The backbone of the study has been centralized records, which have been kept for the past 50

Donald Goodwin

years, of every admission to psychiatric hospitals in Denmark.

In the beginning, the researchers recorded names of 5,000 men and women who had been adopted, and who were 30 years old at the time. From the central government adoption agency, they obtained the names of the 10,000 biological parents.

Both sets of names were put into a computer which also contained the records of the psychiatric hospital admissions. It has thus been possible to find out if the adopted adults had parents who had been admitted to psychiatric hospitals for alcoholism.

Dr Goodwin said the evidence is that the children whose parent or parents were alcoholic, and who themselves were brought up by adoptive parents who were not alcoholics, have had a much higher rate of alcoholism in adult life than those who were adopted and who did not have biological parents who were alcoholics.

Dr Goodwin pointed out that such a study is not possible in North America. "The one thing you need to know is if there is any alcoholism in the biological families, and adoption records here by and large don't have information about the drinking habits of biological parents."

However, Dr Goodwin has been able to make other approaches to the subject and "while they are not quite as clean, they can be done".

His most recent involved the study of alcoholics who have both full siblings and half-siblings.

"If it is going to follow hereditary lines you will predict that there will be more alcoholism among the full siblings than among the half-siblings. Our preliminary data indicates this may be so, but it is too early to tell yet," he said.

Another study carried out several years ago, and which may be revived, involved interviews with family members, mostly from broken homes, who had had a biological father who was an alcoholic.

"We found that having a biological father who was an alcoholic increased the chances of being an alcoholic sixfold over later having a father of upbringing who was an alcoholic," said Dr Goodwin.

While he thinks that alcoholism can be inherited, Dr Goodwin has no idea what the inherited factor can be. It may just be a capacity to drink an awful lot of alcohol. It may be that however alcohol works to make people "feel good", it works even better among others because of a biological factor.

"It could be a deficiency, or lack of a deficiency. It may be that the people who have the deficiency are those who can't drink alcohol or respond to it so rapidly in their behavior that they decide to deliberately keep down the amount they drink."

Behind bars defenceless

RALEIGH, N.C.—Every police officer and jailer in America should be trained in basic safety measures for alcoholics who are put in cells, says Dr. David Pittman, PhD, of Washington University, St. Louis.

"It is a well documented, established fact of the connection between attempted and successful suicide and chronic alcoholism and 25% of all suicides are alcoholics. For these reasons every conceivable precaution should be taken when an alcoholic is arrested," he said.

Dr. Pittman, a leader in the fight for decriminalization of the public drunkenness offence, said many sophisticated metropolitan areas do offer training to police officials. But in most other areas, alcoholics still manage to commit suicide while in jail "and this is just inexcusable in 1975".

California pot debate renewed

By SAUL ABEL

LOS ANGELES, CAL.—A familiar drama has opened a repeat engagement in the halls of the California State Legislature, but this time there may be some changes in the script.

A bill that would significantly reduce penalties for simple possession of marijuana has passed its first test and has "very good prospects of becoming law," according to State Senator George R. Moscone of San Francisco, author of the measure.

The bill won approval of the Senate Judiciary Committee, considered a formidable test, by a vote of seven to three, one more than required. It goes next to the Senate Finance Committee, and is expected to clear that group readily.

"The outlook for passage of this bill is excellent," Senator Moscone told **The Journal**. "I am confident we will have at last in California a sane and reasonable law on marijuana possession."

For the past several years, State Assemblyman Alan Sieroty of Los Angeles, and other legislators, have authored similar measures to reduce marijuana penalties. A number of these bills have passed both houses of the legislature, only to be vetoed by former Governor Ronald Regan (**The Journal**, February and April, 1973).

Strong efforts also have been mounted to pass a marijuana initiative measure, but without success. In 1972, such an initiative was rejected by the electorate by a two-to-one margin, and in 1974 the initiative failed to secure enough signatures to be placed on the ballot (**The Journal**, April, 1974).

Should the Moscone bill win approval of the legislature, it will very likely become law, as Governor Edmund G. Brown, Jr., has stated he will support marijuana legislation in the pattern of a recent Oregon statute.

Like the Oregon law, the California marijuana measure now being considered, makes possession of one ounce or less a misdemeanor, subject to citation rather than arrest, and liable to a maximum penalty of $100 fine.

Transportation of one ounce or less, or giving (not selling) that amount to another person, would also be a misdemeanor, subject to a maximum $100 fine. Possession of more than one ounce would be punishable by a maximum of six months in jail or $500 fine or both.

Arrest and conviction records in personal use cases would be automatically purged after two years, and this provision would be retroactive.

By contrast, present California law on simple possession, among the harshest in the nation, allows it to be treated as a felony, with possible sentences of one to 10 years.

Prisoners' rights

RECOMMENDATIONS ON how to conduct drug testing in prisons while safeguarding the rights of prisoners, have been published by the National Council on Crime and Delinquency in the United States.

They were drafted at a conference of representatives from medicine, law, corrections, civil rights and prisoners' groups.

Copies of the summary report are available from the Public Education Department of the National Council on Crime and Delinquency, Continental Plaza, 411 Hackensack Avenue, Hackensack, New Jersey 07601.

Accused of misrepresenting members

CMA defends cannabis stance

A GROUP of 12 physicians has charged the Canadian Medical Association executive committee with misrepresenting the views of the membership in recommending decriminalization of simple marijuana use to the Senate.

In a telegram to the CMA Board of Directors, the group says the committee acted "in opposition to both the spirit and wording of the resolutions of the last three CMA General Council meetings".

In reaction to the telegram, Dr. John Bennett, secretary of the CMA's Council on Community Health, dismissed the charges as unsubstantiated and said the people now disputing the CMA brief had every opportunity to challenge it on the floor of General Council last summer.

Except for the 12 people signing the telegram—several of whom have repeatedly criticized CMA drug use policies—"we have not had one letter of criticism from members of the CMA, not one," emphasized Dr. Bennett.

The telegram, which urged "immediate public correction" of the CMA's viewpoint, listed psychiatrists Dr. Andrew Malcolm, formerly of the Addiction Research Foundation of Ontario; Dr. Conrad Schwartz, of the University of British Columbia; and Dr. Frank Lundell of McGill; as contacts for the group.

Bette Stephenson

In its appearance before the Senate committee on legal and constitutional affairs, which is now considering law changes that would transfer cannabis from the Narcotics Control Act to the less-stringent Food and Drugs Act and make cannabis penalties less severe, the CMA said use of drugs per se should not be a criminal offence.

It urged the federal government to change the drug laws so people found guilty of simple possession of cannabis (marijuana and hashish) for personal use do not receive criminal records.

Failing that, the national association representing some 26,000 doctors in Canada called for automatic erasure of the criminal record for those found guilty of cannabis possession for personal use after a two or three-year "charge-free probationary period".

Dr. Bette Stephenson, president of the CMA, also called for less harsh methods of dealing with cannabis possession charges, citing a concern about the future mental and emotional health of those convicted of simple possession.

The CMA maintained in its brief to the committee that "in those cases where use" of cannabis "is associated with or leads to activities which contravene existing civil or criminal law, the appropriate existing laws should apply." Cannabis possession by itself should not be against the law.

The association stressed, however, it is not calling for legalization of cannabis. At the same time, agreed Dr. Lionel Solursh, a Toronto psychiatrist and member of the CMA delegation to the Senate hearing, the CMA's position, if accepted, might encourage some "fence-sitters" to start using cannabis. This might thus increase

Lionel Solursh

the number of users somewhat "but we would hope not significantly."

Dr. Stephenson noted that other aspects of cannabis—trafficking, importing and cultivation—would still be illegal and therefore the drug would be controlled federally, thus many people would continue not to use cannabis.

The CMA argued it "must strongly disagree with the retention of the criminalization which may result from simple possession and reiterates its opinion—that criminalization frequently produces far more serious deleterious effects on the user than the original use of cannabis".

At the same time, the CMA urged that the public be made more aware of the potential hazards involved in the use of cannabis.

The crux of the dispute, raised by the dissident group, is whether or not General Council at any time approved the recommendations of the CMA subcommittee on Non-Medical Use of Drugs urging elimination of criminal penalties for simple possession of marijuana.

The group argues that such approval was never given, that General Council intended to confine any CMA policy statements to discussions of the medical hazards of marijuana, and not to "complicated legal issues".

The telegram states that the legal issues were to be discussed by a special CMA-CBA (Canadian Bar Association) committee and were to be reported back with recommendations for Council to debate.

The group further says this liaison committee never reported back, but historical record of council meetings shows it did, and that its recommendations were approved.

Dr. Bennett notes that at the CMA's annual meeting in Vancouver in 1973, General Council referred the following two resolutions to the Board of Directors and the CMA-CBA joint committee for action: (1) That the simple possession of cannabis products for personal use be no longer a criminal offence, (2) that the CMA does not favor legalization at this time.

The CMA-CBA liaison committee did report back, and its recommendations favoring decriminalization were integrated into the Board of Directors report which was endorsed by General Council at the 1974 annual meeting in Toronto.

Dr. Solursh said the CMA had shied away from advocating legalization of cannabis in large part because this might lead to widespread acceptance of the drug, and also in part because it would lead to the creation of an industry with a vested interest in producing and distributing cannabis products.

Government closing 'pardons' gap

By BRYNE CARRUTHERS

OTTAWA—The federal government is considering making it a criminal offence to disclose that an individual has a criminal record once that person has been pardoned.

The move, according to Solicitor-General Warren Allmand, would be designed to close one of a number of gaping holes in the Criminal Records Act. The Act now forbids federal agencies from revealing criminal records after a pardon. But it does not prevent provincial or municipal agencies (including courts) from keeping records of convictions covered by pardons or newspapers and credit agencies from reviving criminal records after pardons.

Curiously enough, as a survey last year by **The Journal** revealed (June 1974), the existing Criminal Records Act is not even tough enough to prevent federal agencies from retaining criminal records after pardons have been issued.

The bureau of dangerous drugs in the federal health department, which keeps extensive files on known and suspected drug users, admitted it had not been deleting records of pardoned persons because it had not been receiving the pardon notifications in the first place.

That situation, federal officials say, is now being corrected.

Federal government sources also revealed the government intends to take legislative steps to lessen the amount of time it takes to finish the special investigations needed for determining whether a pardon should be granted or not.

The Journal also revealed last year that investigations carried out by the RCMP often take a year or more. And the fact that such investigations into the family, sex, and job life of a person applying for pardon (to wipe the criminal record clean) are needed makes rather a farce of the special early-pardon-eligibility features of the conditional and absolute discharges granted some people found guilty (but technically not convicted) of cannabis crimes such as simple possession.

Mr. Allmand indicated the government intends to try and eliminate many of the deficiencies relating to these investigations and to judgements the Parole Board might make as a result of such investigations. In a Commons debate, the Solicitor-General said the existing Criminal Records Act requires the parole board to determine that an applicant has been "of good behavior" before granting a pardon.

Black market cocaine threatens

AN AMERICAN authority on drugs has warned there will be serious consequences if the black market becomes flooded with cocaine, the drug said to give "the highest high of all".

Large amounts of cocaine are already being smuggled into the United States, according to Dr. Sidney Cohen, former director of the division of narcotic addiction and drug abuse, National Institute of Mental Health.

For the moment, the distribution pattern appears to be concentrated in larger cities. And the principal consumers are multiple drug users with only small numbers exclusively using cocaine, he said.

However, if the black market is flooded with the drug, "it can be predicted that many more people will become involved, more 'cokeheads' will appear, and more social problems such as impulsive, violent activities will become manifest".

Dr. Cohen, a clinical professor of psychiatry at the Neuropsychiatric Institute, University of California, Los Angeles, was writing in *The Journal of the American Medical Association* (Jan. 6, 1975).

"It should be recalled that the stereotype of the crazed, homicidal 'dope fiend' was the cocaine user, not the heroin addict," Dr. Cohen wrote.

He added, however, that "even for the cocainist, the 'dope fiend' stereotype ordinarily does not apply".

Cocaine abuse, said Dr. Cohen, falls generally into four categories:

The pure 'cokehead': — A small number of people exist who try to maintain the "high" throughout waking hours. It is an expensive procedure with high quality cocaine selling for about $1,000 an ounce. Street cocaine is generally adulterated with lactose, procaine, amphetamine or strychnine. Cocaine content, if there is any, may be as low as 5%. Intravenous injections, as often as every 10 minutes, are necessary to maintain the upper reaches of the cocaine state. This means dozens or hundreds of injections a day, said Dr. Cohen.

Polydrug users and cocaine: —A common pattern is to try cocaine when it is available but to use other agents for everyday use.

In combination with heroin: —Cocaine produces too much jitteriness and excitement for some people and they prefer to combine it with a narcotic or some other depressant.

In methadone maintenance: —Although methadone can prevent the heroin "high", it will not prevent cocaine, amphetamine or sedative "highs" and

Sidney Cohen

some patients in methadone maintenance programs have been found to be using cocaine, said Dr. Cohen.

Crunch for NCAE?

WASHINGTON—Advertised as a multi-million dollar "centre for excellence" when it was set up two years ago, the National Centre for Alcohol Education may now be facing an early and less than illustrious end.

For the moment, it is in the last weeks of a commuted sentence and prospects for its existence beyond the end of this month are, at best, uncertain.

The centre was set up by the National Institute on Alcohol Abuse and Alcoholism for development of curricula and training systems, information dissemination through seminars and other means, and general consciousness raising.

NIAAA awarded the first operating contract to University Research Corporation and has invested more than $3 million—one estimate says $5 million—in the centre.

The jolt came last summer when NIAAA advertised for bids from companies to take over the operation of the centre from URC, thus implying dissatisfaction with the way the centre had been handled, despite previous acknowledgements to the contrary.

The next jolt came when all three of the bidders—URC, General Electric, and Abt Associates—were turned down with no explanation.

URC's contract expired at the end of 1974 and late in the year, it seemed the centre would expire with it. NIAAA, however, decided against cancelling. It settled for a scaled-down operation rather than a complete shutdown and granted URC a three-month extension.

That ends on March 31st and the $2¼ million contract comes up once again for bid.

Except for an early incident involving a possible conflict of interest issue, a long and successful future for the centre seemed assured.

That issue arose with the appointment of Dr. Irving Wolf, a former psychology professor, to the directorship of the centre.

Dr. Wolf had helped to develop the concept of the centre when he was on staff at NIAAA. He also headed the NIAAA committee which awarded the operating contract to University Research Corporation. Then, he was hired by URC to head the centre.

Attitudes evenly divided on cannabis laws: U.S. survey

AMERICANS are evenly divided in their attitudes toward changing existing marijuana laws.

According to results of a national survey commissioned by the Drug Abuse Council, 40% of those surveyed want the cannabis laws made tougher for possession of small amounts, 39% favor the elimination of criminal penalties for the sale and/or possession of small amounts of the drug, and only 13% are content to have the laws remain unchanged.

As was clearly suggested by a survey in Oregon, those in favor of tougher restrictions are primarily the older age groups and those who have never tried the drug.

In the national survey of those who have used marijuana (and 18% of the surveyed group indicated they had) 82% favored a reduction in criminal penalties. Of those who have never used marijuana only 30% favored the reduction and opted for the status quo.

As was indicated in the Oregon study and confirmed in the national survey, the greatest support for easing the marijuana laws rested with the younger groups.

As the sample grew older the support for lenience dwindled. In the national survey, only 19% of the 18-to 25-year-olds surveyed preferred tougher penalties. Of those beyond age 50, 54% wanted the marijuana laws stiffened.

The national sample, which included 2,133 adults and 505 teenagers, indicated 18% have at one time used marijuana and 8% currently use the drug. Of those in the 18-to 25 age group, 49% reported having used the drug and 25% are currently using it.

In the over 50 year age groupings, only 1% report currently using the drug.

Among younger age groups—5% of those in the 12- to 13-year level have used marijuana, 14% of 14-to 15-year-olds have tried, and 23% of the 16-to 17-year-olds have tried.

Among adults, the highest users are professional people—28% have tried marijuana and 14% currently use the drug. It was also revealed that 40% of union members surveyed have tried marijuana. There were also interesting geographical trends revealed in that marijuana use seems to be more concentrated in the West (27% of westerners surveyed had used the drug) and the Northeast (22%).

In north-central and southern states, use remained below the national norm—13% and 14% respectively.

The survey also showed a trend in marijuana use as related to political affiliation. Of Republicans, 10% reported having tried marijuana and 3% were currently using. Of Democrats, 15% have tried and 7% are currently using marijuana, and of Independents, 24% have tried and 19% are currently using.

Of those currently using the drug, 50% do so no more than two or three times a month and 18% at least once a day.

A comparison of the Oregon and national surveys indicated one important difference in attitudes to the law. Oregonians, after living one year with decriminalized marijuana use, were much more strongly in favor of civil, non-criminal penalties than were those in the national sample who had not experienced the decriminalization process.

In the national sample, only 10% of all respondents supported the use of civil fines to penalize marijuana users. In the Oregon sample, 32% supported the retention of civil fines.

In Oregon, 33% of those who had never used marijuana opted in favor of civil fines as the most appropriate mechanism of penalty. Of the national sample, only 11% of those who had never used marijuana supported the concept of civil fines as penalties for users.

The current surveys are part of a series commissioned by the Drug Abuse Council. Forthcoming in this series is a survey of marijuana usage and attitudes in the state of California.

The National Commission on Marijuana and Drug Abuse estimated in 1971 that 24 million Americans had tried marijuana and 8 million were using regularly. The Drug Abuse Council surveys now indicate use to have risen to the point where 29 million have tried marijuana and more than 12 million are regular users.

Children 'smashed and even comatose'

WINNIPEG—A startling increase in alcohol consumption by children has child care officials in Winnipeg worried.

And the mounting statistical toll may be only the tip of a drinking iceberg among Winnipeg's 10- to 16-year-olds.

One who is particularly alarmed with soaring alcohol consumption by children is Dr. Charles Ferguson, medical director of ambulatory care at the Children's Centre of Winnipeg's Health Sciences Centre.

In recent months, Dr. Ferguson said his department has seen an average of one severely inebriated child per day, something that was unlikely to occur even a year ago. And the incidence of alcohol misuse by children seems on the increase.

Dr. Ferguson told a public meeting on child placements that during one recent week his department treated four youngsters; three of them were so drunk they had to be admitted to hospital.

"They come in falling down, smashed-drunk and even comatose," Dr. Ferguson said.

Most of the youthful problem drinkers admit they are in their teenage years, and a few are as young as 10, the physician added.

"This has been a trend that's been going on for about a year," Dr. Ferguson told **The Journal** in an interview.

"It has also been reported by Dr. Martin Walfish of Toronto, who says they are also seeing more acute inebriation in children now than ever before."

Dr. Ferguson added: "One wonders whether the difference between now and before may be in their being apprehended. I suppose in times past the kid went upstairs and the father booted him one and stuck his head in the bathtub and made him sober up overnight. Now they seem to get into some sort of contact with peace officers and other people who naturally feel that they need some medical care, so they are brought to the hospital."

Most of those severely intoxicated are brought into the Children's Centre at night and on weekends, Dr. Ferguson said. About half the young patients are males and half are females, he added.

Dr. Ferguson denied earlier reports he had called for the creation of a detoxification department for children in the Health Sciences Centre.

ALCOHOLISM FACTOR IN BURN CASES

ALCOHOLISM WAS the most prominent predisposing factor identified among "burn-prone" people in a study of 155 adults treated for burns at a Boston hospital.

Senility, psychiatric disorders and diseases of the nervous system followed alcoholism as most common predisposing factors, according to the authors of the study, Drs John D MacArthur and Francis D Moore.

The study was reported in *The Journal of the American Medical Association* (Jan. 20, 1975).

The burn-prone patient is "somewhat more likely to be a woman, with alcoholism or drug use in the background and ignition occurring initially in the patient's own clothing or hair," the doctors reported.

"Alcohol is a terrible hazard," Dr. Moore said, adding that burns are just another way in which "alcohol takes its toll".

In an editorial accompanying the report, Dr. Moore said despite improvements in burn therapy, "there has been little improvement" in the death rate from burns over the last 25 years.

The surgeons estimated at $50,000 the bill for the 50 professionals needed to treat and rehabilitate a 50-year-old man who suffered burns over half his body.

Oregon survey

CONCERN ABOUT health dangers is a greater deterrent to marijuana use than is fear of legal prosecution, according to a recent survey in Oregon, the first state to abolish criminal penalties for simple possession of the drug.

The survey, sponsored by the Drug Abuse Council, reveals that of the current non-users in the sample, only 4% said they were kept away from the drug by the fear of the law, while 53% said they simply had no interest in the drug, and 23% feared damage to their health.

In October 1973, Oregon abolished criminal penalties for possession of one ounce of marijuana or less and replaced them with a maximum civil fine of $100.

Of the 802 people interviewed in this survey only four who currently use the drug were introduced to it after the change in the law was made—that is one half of one per cent of the total population sample.

Of the 9% of Oregon adults who claim they currently use the drug, 40% have reduced their usage since the de-criminalization action, 52% report no change, and only 5% report using more marijuana than before the change in the law.

For the child, 10 years of indoctrination ahead.

Hare Krishna

An answer for some

By JEAN McCANN

CLEVELAND—Can Hare Krishna succeed with drug abuse problems where psychotherapy has failed?

Chanted once daily for two hours, yes it can, an orange-robed disciple of the Krishna Consciousness movement told a recent meeting at the Cleveland Psychiatric Institute.

John Agostin, a former patient at the institute, told his audience of psychiatrists and other workers in the addictions field, that he was not able to quit taking drugs until he joined the movement several months ago.

"I felt frustrated at the hospital. I tried the program here and it didn't work," Agostin told the audience.

"The entire movement hinges on the chanting of Hare Krishna (Hare Krishna, Hare Krishna, Hare, Hare, Hare Rama, Hare Rama, Rama Rama Hare Hare) at least two hours continuously every day.

"Doing this is what has helped me, and relieved my distress", added Agostin, who, like others in the movement, has his head shaved except for a small pigtail in back, and who customarily spends hours chanting "Hare Krishna" on downtown street corners.

Agostin explained that "Hare" (Har-ay) means energy, and Krishna and Rama are the names of God.

"So we're addressing the energy of God. We're calling upon the energy of God for realization.

"The kind of psychotherapy I received previously was all directed to finding out who I was, but this is more practical, I think. The first day I entered the movement and seriously took up the chanting of Hare Krishna, I found myself relieved of my distresses and the need to take drugs."

Agostin said he now spends his time, in addition to chanting, as a student of Eastern scriptures. He lives in a "temple" with other devotees of the movement, including Michael Stockwell, who also spoke and chanted to the CPI audience.

"We haven't taken a strict census, but we understand the majority of those in the Krishna Consciousness movement have taken drugs or experimented with them", said Stockwell, a vice president of the Cleveland temple.

"Drugs are not in the self-interest of the person who's taking them, so since drugs have been determined to be harmful, they've been outlawed" he added, by the more than 50 Hare Krishna Consciousness centres, most of them in the U.S. and Canada.

"What we'd like to demonstrate to the adult population is that this movement is not just an escapism, or a transferring of one type of habituation or escapism of reality for another. Rather this is a process by which one can have positive authorized direction in life, and can keep making progress in life.

"It also eliminates self-created unnecessary problems like dependence on drugs, which are condemned basically for the reason that they are destructive and do not provide any good result."

The two Krishna disciples were invited to speak at the CPI by Dr. Irving Rosen, training director for this psychiatric facility on the grounds of Cleveland Metropolitan General Hospital.

In this movement, he said, "things are clearer, even though some of the explanations they have for what is going on may be pseudo-explanations.

"In the movement, the patient feels acceptable, even though he has been a drug addict or a mental patient. And he is not only accepted, but it's perfectly clear to him what he has to do to continue to be accepted. Life outside the movement is more complicated."

Dr. Rosen told **The Journal** he believes other movements which have helped drug addicts, may have some of the same advantages as the Krishna Consciousness movement.

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Cannabis: We're missing the point

THE MOUNTING evidence that cannabis is not a benign weed has become a compelling argument against its regular, prolonged use.

But manipulation of this evidence to obstruct much-needed changes in our existing cannabis laws benefits no one. The law as it stands today is itself subject to great abuse. All too often, it leaves scars that are way out of proportion to the severity of the "crime".

If the intent of the law is to deter someone from inflicting harm on himself, how can one justify the immense personal damage that is often the spin-off of a criminal record?

The fact is existing cannabis laws and the growing medical evidence that cannabis is potentially dangerous to health, are two separate issues. There is no justification for retaining the laws as they stand today—certainly not those against personal use.

The rationale for advocating legal deterrents to drug use goes something like this: The more easily accessible a drug becomes, the more freely people will use it, and the more often they will run into problems.

If a legal deterrent *could* suppress this use, then the rationale would remain intact and supportable. But in the case of cannabis, this deterrent effect has never materialized.

To use one recent example: Only one half of one percent of all the people surveyed in Oregon, during that state's move to decriminalization, avoided marijuana use because of any fear of the law.

At the same time, 23% rejected using marijuana because they were concerned for their health: They moved from marijuana because of what they heard, what they saw, and what they read—not because of fear of the law.

Surely this says a great deal for the potential of public education in tempering people's attitudes toward drug use.

Many of today's "hold the line" advocates argue that decriminalization, to whatever degree, will be seen by the public as endorsement of cannabis.

There is that risk. But it can be minimized if the act of decriminalization is counterbalanced by programs that will give the public intelligent interpretation of the physical, psychological, and social risks involved in regular, prolonged cannabis use.

In its recent brief to the Senate cannabis hearings, the Canadian Medical Association had no difficulty reconciling a plea for decriminalizing personal use of cannabis with its concerns about specific health hazards associated with use of the drug—irreversible brain damage, personality changes, damage to the lungs and breathing system, interference with hormone production, genetic chromosome damage, and disruption of normal body cell functions.

The identification of such risks in a rational, honest context, might make a considerable difference in how people come to regard this drug. But, how can we expect the millions of potential cannabis users in our society to put any faith in the growing accumulation of scientific evidence, when that evidence is used primarily as a means of propping up our existing, hypocritical laws?

When stills run dry

IT'S THE SAME all over.

Inflation is terrorizing every segment of society.

The latest to feel the sting are the hill people of the southern U.S. to whom sugar—necessary for the output of the stills—has become a rarity. Used to be people in the hill country would turn out a bit of sugar on their doorsteps at night just before turning in, just the way some regularly turn out the cat (See page 9).

The trade-off would come later, when the sugar, stirred into the mash, would yield a jug of grandad's old lightning.

Well, with the price of sugar these days, nobody turns it out on the doorstep anymore and it seems "old grandad" is in short supply. The stills are simmering away a mere drip at a time.

There is a suggestion. The Hare Krishna enthusiasts (see page 5) seem confident that chanting two or three hours a day offers a positive alternative to drug use.

If some of the Hare Krishna converts were to venture into the backwoods and spread the validity of chant, it would give the hill people something to do, give them an alternative to commiserating with each other about the slowed down dripping of the stills.

Come to think of it, the traditional music of the hill people might just pick up an exotic lilt from the rhythms of the Hare Krishna group.

One problem: Before the Hare Krishnas go into the hills they should perhaps spread out some kind of advance men, some kind of promotion. There's just no way the Hare Krishnas look like "revenooers" but when the shotguns are loaded, the stills are dry, and there are strange looking beings in orange robes trucking on up the road . . . the trigger finger can get mighty itchy.

Best idea, maybe the Hare Krishnas ought to strap on some heavy vests. After all, it does get kind of coöl in them thar hills at night, especially when there's not much steam coming off the old stills.

Letters to the Editor . . . page 12

Poignant problem for lovers

OR how science is wrecking it for modern nymphs and shepherds

By WAYNE HOWELL

Hard on the heels of news from Miami that chronic marijuana use can result in gynecomastia (enlargement of the male breast) and a lowering of the blood levels of testosterone (the male sex hormone), comes news from San Francisco that marijuana is "unparalleled" in its ability to act as an aphrodesiac and enhance sexual pleasure. This creates a poignant dilemma for young lovers which is most appropriately explored—with the assistance of Christopher Marlowe and Sir Walter Raleigh—in verse:

The (Modern) Passionate Shepherd to His Love

Come live with me and be my love,
And we will all the pleasures prove;
Dagga, Kif, and home grown Grass
Will make our love forever last.

The vinous draughts we shall eschew,
For 'though they make desire brew,
Shakespeare said we pay a price—
'Tis performance we must sacrifice.

Since experts say it's Outasight
The fires of love with Grass we'll light,
In valleys, groves, hills, and fields,
Woods, and steepy mountain shields.

By shallow rivers to whose falls
Melodious birds sing madrigals,
In places such as this we'll come
For on the Grass it's twice the fun.

And I myself shall dance and sing
For thy delight each May morning;
If these delights thy mind may move,
Then live with me and be my love.

The (Modern) Nymph's Reply to the Shepherd

If all the world and love were young,
And truth in every shepherd's tongue,
These pretty pleasures might me move
To live with thee and be thy love.

But flowers do fade, and wanton fields
To wayward winter reckoning yield;
If to thy blandishments I succumb,
What of months and years to come?

A honey tongue, a heart of gall,
Is fancy's spring, but sorrow's fall;
Might to the winds our love be blown
When pot depletes Testosterone?

I'd live with thee at thy request,
But what of stirrings in thy breast?
Might not love lose its verdancy
If thou get Gynecomasty?

But could youth last and love still breed,
Had pot no flaws nor age no need,
Then these delights my mind might move
To live with thee and be thy love.

(Wayne Howell is an Ottawa physician and freelance writer)

CFADD moving in new direction

'a kind of social advocate for Canadians'

By ANNE MACLENNAN

OTTAWA—CFADD? To blame anyone for not immediately recognizing those letters as standing for the Canadian Foundation on Alcohol and Drug Dependencies would be, at best, unfair.

In its 20-odd years, the CFADD has not, as they say in The Field, kept a high profile.

Indeed, it has amounted to little more than two meetings (of the heads of Canada's provincial alcohol and drug commissions), and two sets of minutes, a year.

But, that is about to change. If it doesn't, and dramatically, there may be no CFADD come mid-1977.

The plan, allowed for by a change in constitution in 1974, is to make CFADD the "voice of the

Dennis Taylor

people in the field" rather than the "exclusive club" it has been, says Dennis Taylor who became executive director and the first paid staff member last April.

"We want to get to the people . . . all the interested and concerned people in the field . . . not just through agency or foundation memberships but through individual memberships.

"That means the conservative and the radical, the distress centre worker and the commission executive, the counsellor and the little old lady who helps . . . the whole gamut.

"If we end up being essentially the conservative elite, I think we will have failed. If we end up as the spokesman for only the radicals or the distress centres or the street clinics, I will feel we have failed.

"The ideal to me would be to have all of the tensions that exist in this field in Canada reflected around the board room table of CFADD."

That is the aim. The problem, is money.

For the moment, Taylor and his staff of six—a project director, information officer, administrative assistant, and three secretarial assistants—are "working hand to mouth".

The budget for 1975-76 is $147,000 and "we could use another $90,000", says Taylor.

Of the $147,000, $125,000 is from the Non-Medical Use of Drugs Directorate; $15,000 is from the health protection branch of national health and welfare; and $7,000 is from the provinces.

The $125,000, however, is part of a three-year innovative services grant and it terminates at the end of the fiscal year, 1976-77.

Between now and then, CFADD is going to have to prove its worth —if it is going to receive what will then have to be sustaining rather than innovative assistance from the government. And the only way it will be able to prove it is needed will be to have an active membership.

"At the end of two years, we have either an established organization with credibility and membership and action at the national level, and a financial structure of our own, or we will be finished."

It looks a mammoth task. Taylor believes a membership that could cover about 20% of the budget (by 1977) would reflect sufficient member-interest in the organization to warrant continued government assistance.

At $20 each for individual members and $50 for agency members, that means CFADD needs about 2,000 individual and 200 agency members. At present, membership has only just passed the 100 mark —although as Taylor and his staff point out—"We've just begun."

Given the members, CFADD will do two things, according to Taylor. "Represent and serve."

"Represent in terms of presenting its opinions to national associations which operate in related fields, to government committees at the provincial or federal levels, to funding sources, and so forth. And present it as a community of concern before the media and public at large.

"Serve it in terms of saying you have needs that you identify to us and we try to respond to them. Those needs may relate just to our having co-ordinated information available.

"If we are successful in attracting people, we can provide an input to organizations like the Addiction Research Foundation of Ontario—big as it is, wealthy as it is and well-respected as it is—in terms of changes in policy. We can say: 'Keep this or that in mind . . . '. More important, people in Ontario will have another vehicle to get through to ARF and express concerns.

"It all hinges on members. If people sigh 'Oh, another organization', then I think that speaks on behalf of the need. We are not setting up another national organization for the sake of having another national organization. There was a feeling there was a need and I too now believe that there is one."

Roger Richard is treatment director of Quebec's OPTAT (l'Office de la prevention de l'alcoolisme et des autres toxicomanies), and general secretary for five years of CFADD.

Says Richard: "If CFADD is sensitive to the needs of the indi-

Roger Richard

vidual members, it will become really strong, particularly if it gives feedback to individual members. These people need more than the provincial agencies.

"The big agencies exchange information all the time. If we need services, we organize them. If we don't need them, we close them."

He sees a successful CFADD as "a kind of social advocate for the Canadian population, a strong body able to face the federal government and represent the Canadian people, the Canadian thought.

"There are so many people working with alcoholics and drug addicts not integrated into any special organization.

"If they have a place where they can go to get resources, to get new ideas, support, information, I think the foundation can become really very dynamic."

Richard believes with Taylor that the new CFADD owes a considerable debt to the provincial officials who made up the former CFADD—for recognizing the need for change and for making the change consitutionally possible.

"I think they have done something important. They worked to keep the CFADD together but then I think recognized the time was good to pass to another line of action and to assume a greater co-ordination."

That the role of CFADD must change became increasingly apparent through the 1960s.

The foundation began in the early '50s as the Canadian Council on Alcoholism essentially because there were institutions in several provinces which saw a need to meet once or twice a year to exchange information and experiences. They also saw the possibility of encouraging development of similar organizations in other provinces and the opportunity to provide guidance.

With the growth of the provincial network, however, and exchange of information at other levels and in other meetings, twice-yearly meetings ceased to be a valid raison d'etre for the foundation.

About the same time, explains Taylor, there was a growing feeling that there was a need for a private national association in the field.

"Some of the smaller provinces or less wealthy ones had begun to believe that Ontario, Quebec and Alberta were dominating, by sheer weight, the nature of discussions on the national level and nature of the influence on federal government" he says.

Too, some were beginning to point to the large gap in representation at the national level—"there was no spokesman for John Q Citizen at the federal level in the drug and alcohol field".

While these feelings were "stumbling into prominence" in CFADD, says Taylor, NMUD was becoming operational and beginning to recognize a need for an agency other than provincial commissions with which to interact in terms of finding out what was going on, why, and where.

"There are private agencies which will give out no information, even to provincial governments, and a lot of people concerned about governments being too involved," he says.

"Jealousy is also a real fundamental force here. There are provinces that will not write, say to ARF, for their publications but will write to us and ask what ARF is doing."

In the 1970s, "all of these things came together", says Taylor. The constitution was changed to permit individual memberships so that CFADD could "embrace all interested and concerned agencies and individuals.

"It's there. It's going to be a tremendous task because if we don't get members, what do we do? And unless we get members, how do we serve them?

"But, we are not just interested in pulling together 1,000 members or 2,000 and having their names on a list.

"The whole idea of CFADD is involvement, not telling people what they should believe but giving them as much of the information as is available, putting them in touch with each other, reflecting their feelings . . . even if that only means refleeting confusion."

The ultimate goal? "To work towards a system that would stimulate and encourage a society where people are conscious of the right that they have, through personal decision, to influence the activities and forces of their lives . . . a self-conscious society.

"To bring together a group of people who are involved and concerned in this field—to produce a whole, a cohesive whole. To create a community and do something with it."

QUEBEC CITY—The president of the Canadian Foundation on Alcohol and Drug Dependencies occasionally wonders aloud whether the organization shouldn't have a "prestige" president, according to executive director Dennis Taylor.

To some considerable extent, it already has one whether or not the president herself recognizes it.

Mary Lamontagne, who has undergraduate degrees in philosophy and chemistry, is a member of the Medical Research Council of Canada and the Vanier Institute of the Family, served on the board of governors of Laval University for five years, was the first (in 1971-72) woman to be president of Laval Alumni Association, and is a founding member of the Quebec section of the United Nations Association.

She is also, however, the wife of a politician, a mother, a student doing postgraduate work in philosophy, and a founding member and worker for an agency in Quebec City which advises and assists pregnant women.

The strange and unusual juxtaposition of roles—student with university governor, politician's wife with woman concerned about government involvement, comfortable matron with friend of often-troubled and deprived pregnant women, professional with foe of professionals who lack the human touch—has not left Madame Lamontagne without conflict.

However, it has strengthened her own conviction that is it is becoming painfully and increasingly necessary for people to make themselves heard above the din of advancing technology.

It is as one of "the people" that Madame Lamontagne has taken on the role of CFADD president.

"We have simply gotten too far away from the real human values. Technical development should relate back to the real peo

Mary Lamontagne

ple. But somehow we are moving further and further away.

The role of the foundation, she maintains is to work with and for people.

"We want to group together people as people. CFADD should put the people . . . the little people and the big if you like . . . in the field in contact with each other.

"I don't think we can afford in this country to have people competing with each other."

If bringing people in the field together is one of her aims for the foundation, a close second is raising public awareness about addictions.

A pragmatist and individualist, she believes solutions to the problem of addictions—whether to alcohol, illicit or illicit drugs—are ultimately in the hands of each individual.

"Nobody can solve anyone else's problems. The solving of problems must lie with the individual. However, the only way a person can solve a problem is to know exactly what it is.

"We should and must work together to raise public consciousness in this whole area. I think people are not really aware at all of just how much it affects them.

"I have seen many people, for example, gradually becoming addicted to medically prescribed drugs. And they just do not realize they are one of the addicted."

As for government involvement "even if my husband is a politician (the mayor of Quebec City) I worry about government".

"It is rather childish saying we want government to pay for everything and at the same time not want them to make the decisions. Everybody wants somebody else to make decisions for them.

"It's easy for example, as a wife, to want your husband to make all the decisions. But it shouldn't be that way. We all have our opinions. They are valid, if they are informed, and should be expressed.

"If the government is giving us the money, fine. The important thing is giving people all the information, finding out what they want and need, and getting them to tell the government."

It means making a commitment but one gets the impression Madame Lamontagne is one to make commitments.

"There is a certain amount of security in your own little world and it's easy to stay there. But, it is too easy to pass the buck . . . people are doing it all the time.

"When will people realize how much liberty they have? They have to realize it and stand up and make use of it."

Union advocated

Must preserve role of ex-addict

THE FORMER director of a methadone program is establishing a union of ex-addict paraprofessionals.

His reason? To try to preserve the role of the ex-addict in the treatment of drug addiction and to keep alive the self-help concept which, he claims, has produced the best results in the treatment of addiction.

Without the involvement of ex-addicts, the medical model "will be running people back into padded cells and it will all be for naught," according to Edmund H. Menken.

Mr. Menken, who recently resigned as executive director of Marin Open House in San Rafael, a suburban community north of San Francisco, said he believes ex-addicts are essential to the successful treatment of addiction.

Ex-addicts have "come through" on their own and are determined to pass on to other addicts the message that they do have an alternative, he said.

The self-help approach was built on faith, not on drugs and chemicals, he said. Those who had a habit, "kicked it on the living room couch, with a helping hand and consolation from others and nothing more than eggnog for the pain," he said.

Menken, whose 11 year experience in the drug field includes involvement in both a methadone program at Marin Open House and a self-help program at New York City's Daytop Village, reminded participants at the recent North American Congress on Alcohol and Drug Problems that methadone is "simply a chemical that produces a different kind of drug addiction and not a cure".

"Methadone mania has striken the country," he charged, claiming methadone is a "vehicle of the government" and that the government determines who will be treated, how they will be treated and by whom.

"Everyone has been seduced into thinking methadone is the right vehicle, that the medical approach is that right way and that it is all right to provide an individual with addictive chemicals, as long as it is legal and maybe the addict will get a job and lower the crime rate," Menken continued.

Consequently, the model of the old self-help therapeutic community has been lost, he said.

This model, he said, produced "the best results" because it produced "live, sensitive, helping people who were professional healers".

These people understood that the addict "could only recover through a spiritual experience, that he didn't have to give up but he could fight and he could earn peace by putting some effort into it," he said.

This technique, with ex-addicts helping addicts to help themselves, has been cast aside as too expensive, he said.

Despite the energy and resources that have been put into methadone programs, "we are no further than we were 10 years ago, and maybe we are even worse," he observed.

And, in the face of licensing and certification, the paraprofessional ex-addict is "on the way out". Service will be provided by "experts" and the ex-addict will never have a chance to be heard, to have an impact with those who need his help and support, he continued.

Lab studies of alcohol effects misleading

LABORATORY STUDIES on the effects of alcohol may be totally misleading, a study at University of California, Los Angeles has shown.

Marcelline Burns reported that laboratory studies generally fail to take into account the rate of drinking. And this, she said, can significantly affect the findings.

She described a study in which 40 men were given a series of tasks to perform after consuming enough alcohol to produce a blood alcohol level of .10%.

However, the alcohol was consumed at different rates, with one group drinking rapidly to reach the desired blood alcohol level in 15 minutes, one in 30 minutes, one in one hour, and one in four hours. A fifth placebo group served as a control, she said.

Tests of hand steadiness, body sway, visual identification, and visual information processing, indicated that blood alcohol content "alone may be an insufficient measure and that rate of drinking is an important variable which must figure in interpretations of laboratory findings," she said.

The results demonstrated that fast-drinking subjects were more impaired than the slower drinking subjects, she said.

Typically, in a social setting, alcohol is consumed over a long period of time and blood alcohol concentrations are reached gradually, while subjects in most laboratory studies are required to consume alcohol rapidly, she observed.

As alcohol is consumed more gradually, an acute alcohol tolerance seems to offset some of the impairing effects of alcohol, she suggested.

If a laboratory study does not allow sufficient time for this tolerance to develop, then the impaired performance exhibited is not typical of that which would occur with the normal use of alcohol, she said.

If generalizations are to be made from laboratory findings about the hazards involved with social drinking, she stressed, then the difference in rate must be taken into account.

Her test results showed that men who drank their alcohol within 15 minutes performed more poorly than those who drank at a slower rate, while those who reached the desired blood alcohol concentration over a period of four hours, performed consistently better than the other drinking groups, she said.

"Extrapolations from data for subjects who are required to drink rapidly probably overestimate impairment in the case of leisurely social drinking," she concluded.

"Encouraging results" reported

Elderly addicts are treatable

CONTRARY TO a considerable body of opinion, old people addicted to drugs or alcohol are decidedly treatable, according to two recent studies, one in Minnesota and one in Texas.

The studies also suggest the number of addicted old people may be much greater than hitherto suspected.

Margaret Subby, director, Hennepin County Alcohol and Drug Information and Referral, Minneapolis, said a special project designed to help aged addicts there has shown "encouraging results".

In its first 20 months, the project has assisted 324 chemically dependent old people. It counters "the underlying attitude in our society that the chemically dependent aged are untreatable". she said.

Dr. Michael A. Glick, a psychologist with Dallas County Mental Health and Mental Retardation Centre's Methadone Unit, described an existentially-oriented group approach which has proved a useful adjunct for geriatric addicts on methadone.

Ms. Subby said the Hennepin project was designed to fill a gap in services for the aged addict. Housing authorities, apartment managers, social workers, families, and others who had to deal with geriatric addicts had nowhere to turn for help, she said.

The project provides intervention, referral, treatment, and follow-up and utilizes a team approach with volunteers assisting the professionals, she explained.

The chemically dependent aged may be alcoholics or drug addicts. In either case, identification is important, she said.

Geriatric alcoholics fall into two groups—those who have been drinking all their lives and have managed to survive, and those who began heavy drinking late in life, probably in response to loneliness, depression, and the stresses of aging, she said.

Those who started heavy drinking late in life respond without the use of antidepressant drugs, possibly because of the "caring interest" shown by the counsellors or because the project offers early intervention, which is as successful with those beyond 60 years as with younger groups, she said.

The elderly alcoholic is easier to identify than the person taking other drugs, Ms. Subby said. Abusers of prescription drugs, such as Darvon, are particularly hard to identify unless one is aware of such telltale signs as dry mouth, vague conversation, and difficulty in articulating thoughts, she said.

And, although opiate abuse is probably more extensive than suspected, it is difficult to identify because the elderly addict has "cunning ways" of hiding his dependency.

Chemical dependency is a large problem among the low income housing projects in Minneapolis and in other large urban areas because skid row areas have literally been transplanted into the new high rises, said Ms. Subby.

The aging addict does function, but at a very low level and he "may continue to exist, but will not enjoy his remaining years or die with dignity," she said.

In addition to evaluation, diagnosis, and treatment, with appropriate follow-up, for the geriatric addicts, the project prepared seminars for other residents and staff of housing projects, and worked with groups providing services for the aged, she said.

Mary Hager reports from the North American Congress on Alcohol and Drug Problems, San Francisco (Dec. 13-18). Coverage will continue in our next issue.

The success of the project is judged by the improved "social functioning" of many of those involved, the fact a number have received one-year recognition from Alcoholics Anonymous, and the active participation of 197 of the 324 who have been involved in the project, in follow-up groups, she said.

Dr. Glick said the 12 individuals in his methadone group represent a group "supposedly non-existent among most addict populations".

They average 60 years of age and more than 40 years of heroin addiction, he explained, a group most believe to be "either dead or in prison".

As a group, the geriatrics on methadone "have mastered the intricacies of survival and developed adaptive skills far beyond the normal individual in today's complex society," he said.

They have gone "through a metamorphosis from violent crimes toward more subtle methods" of getting drugs in their old age, he said.

Consequently, their needs and their "complex lifestyles" are quite different from those of younger individuals on methadone.

Because this group of long-term addicts was small and necessarily close, the transfer to a treatment group focused on existential treatment, he said.

The individuals in the geriatrics group are unusual, having "successfully existed in a society that has never condoned heroin addiction" and having "successfully established their uniqueness and demonstrated a will to live that exceeds most peoples' inner motivation and striving," he explained.

He noted some characteristics common to the group:

- A low threshold or tolerance for any physical pain since, for most of their lives they have avoided pain through the use of drugs. Therapy, he noted, is aimed at physical and emotional adjustment to everyday pains.
- No real concept or sense of the future, since each was concerned with the present. Therapy involves development of long-term goals and more than half of the group hold jobs, despite their age, he said.
- Highly undisciplined lifestyles and disordered existences. Therapy has tried to help with special health problems, transportation and social welfare problems.

Synanon, AA behind success of new approach

A COMBINATION of the approaches used by Synanon and Alcoholics Anonymous has led to development of a third type of treatment which can be especially effective with both narcotics and alcohol abusers.

Samuel W. Anglin of the Veterans Administration Hospital in Washington, DC, noted that the combined treatment is of special value for recovering narcotics addicts who develop a dependency on alcohol, and for poly-drug abusers.

The combined approach has been used at the VA Hospital for more than a year "with a relatively high degree of success", he reported.

Among specific benefits he cited were:

- The former addict's problems of overcoming loneliness and gaining social growth are eased by participation in the recovery network of Alcoholics Anonymous and Narcotics Anonymous;
- Synanon's intense behavior modification techniques speed up the alcoholic's realization he is an alcoholic and not just a "heavy drinker";
- With the combined treatment, costs are dramatically reduced, since only one facility, one staff, one training program, are required. Self-help aspect also leads to cost reduction;
- In the single setting, individuals receive preventive education on a variety of drugs they may not be familiar with and are also more likely to encounter individuals from other generations and other cultures.

Synanon and AA have similar goals and similar techniques for achieving these goals, Anglin noted.

Self-help is one of the common principles, he observed, noting that, in both, the individual must take the responsibility for his own life.

Also, he said, in both, the "cure" requires "commitment to some larger framework of meaning, some perception of value that places the dependent person in a social body to which he is committed and upon which he is dependent for his growth." A sense of group purpose is essential to both, he said.

Both also depend upon the fact that older members work with new members and members in trouble.

The differences between the two are, in many instances, "simply variations in recovery subculture language," he said.

Problem drinkers can be predicted

MANY MIDDLE-AGE drinking problems can be predicted 20 years in advance, a study by Ms Kaye Middleton Fillmore, Rutgers Center of Alcohol Studies, suggests.

She bases her suggestion on a study of 206 men and women first questioned about their drinking habits while college students between 1949-52. Their ages at the time ranged from 16 to 25 years.

Ms Fillmore said that a major finding in follow-up is that "if an individual exhibits an alcohol-related problem in youth, it can be predicted beyond the operation of chance that he will be exhibiting alcohol-related problems later in life".

The study has found that, for men, the problems which tend to occur early in the drinking career are binge drinking; symptomatic drinking, which includes blackouts and drinking before, or instead of, breakfast; and financial problems.

Later in their drinking careers, these men exhibit frequent intoxication and psychological dependence on alcohol. They also have problems with accidents and the law, as well as with their wives and relatives.

About half of the male drinkers at both points of measurement, and who were problem drinkers in their later 30s and early 40s, showed signs of problem drinking early in life. The other half developed drinking problems in the intervening period.

Ms Fillmore said it was found the men tended to establish their drinking patterns early in life and in the context of all-male drinking groups. Most women tended to establish their drinking patterns later in life, usually after they were married.

The study shows that for women, frequent intoxication and psychological dependence on alcohol preceded symptomatic drinking and problems with friends and neighbors, husbands and relatives.

Belligerence associated with drinking, and health problems, occurred later in their drinking careers.

Alcohol problems exhibited in youth which were most predictive of alcohol problems in middle age were early frequent intoxication and psychological dependence.

Ms Fillmore said: "In other words, if a young female drinker shows these two problems together, the probability is moderately high that she will be a problem drinker in middle age."

As for the men, "it is readily apparent from the data that early symptomatic drinking and either early binge drinking or frequent intoxication are most consistently and significantly predictive of later alcohol problems".

Ms Fillmore emphasized that because the sample is small the results must be considered extremely tentative. However, the findings suggest that if a large sample were studied, a great deal more would be learned of the career process of drinking and of problem drinking, she said.

Kaye Fillmore

SUGAR-FREE MOONSHINE

RALEIGH, N.C.—Soaring sugar prices have dealt a massive blow to a renowned rural family business in the American South—production of "moonshine" or "white lightning."

Production costs are now so high it is probably cheaper to buy the raw corn liquor in state-run retail outlets, North Carolina officials believe. Certainly revenue from the stores rose last year.

It has never been possible to estimate how many gallons of moonshine have been distilled a year, particularly in the mountain areas.

Sugar prices have also denied many families a small source of income. Because massive sugar purchases were too obvious, many moonshiners depended on people, at nighttime, putting a bag of sugar on their back steps. The next morning the sugar would be gone.

Ashley McConnell reports from . . .
an Alcoholism Awareness Week symposium sponsored by the North Carolina Alcoholism Research Authority

Overdrinking: problem of clear understanding

FINDING THE answer as to why people overdrink may lie with the biochemist and pharmacologist, believes Dr Ronald Thurman, who is carrying out fundamental metabolism research at the University of Pennsylvania.

Dr Thurman, assistant professor of physical biochemistry at the university's Johnson Research Foundation, suggested that "why people overconsume may be a socio-psychiatric problem.

"On the other hand, there is a large body of literature which would indicate there is a genetic factor. Now to me genetics means Watson and Crick (of Double-Helix, DNA fame), Watson and Crick means proteins, proteins means enzymes and enzymes means metabolism.

"The question is: If it is genetic, how is this translated into terms a biochemist can understand?"

Ronald Thurman

Dr Thurman said the present knowledge of biochemical deficiency diseases is founded on studies of intermediary metabolism laid down in the 1920's and 1930's.

"What we need to do now is gather the underlying fundamental knowledge in basic alcohol metabolism, aldahyde metabolism and neuromine metabolism in regard to addiction."

Dr Thurman and his colleagues are currently performing a number of biophysical experiments to try and elucidate some of this fundamental knowledge.

He said: "If the problem is one of genetics I can build a hypothesis that will at least give me groups of individuals who would be liable, or non-liable. The non-liable, such as most Orientals, because of their biochemical makeup would never become alcoholic because they cannot drink enough to make themselves alcoholics.

"On the other hand, the Caucasian is liable. Then given the socio-psychiatric pressures they can wind up as one of the four in a hundred who are alcoholics."

Dr Thurman said the biochemist and pharmacologist could produce a substance that "could metabolize alcohol rapidly and it would be cirrhosis-free, if you want to be highly speculative."

There also exists the possibility of a "sobriety pill" that would produce rapid detoxification after a cocktail party "but I don't see it ever being related to the problem of alcoholism".

One practical piece of advice for all drinkers, in Dr Thurman's opinion, is the European idea of the yearly "cure", or abstinence for about three weeks a year.

"The fat that accumulates in the liver goes away. It is not clear if all the pathological changes that occur are reversible, but many of them are."

Eugene LeBlanc

Availability must be first consideration

THERE CAN be no significant action in prevention of alcoholism as long as the present climate continues of incorporating drinking in the life style and making liquor readily available.

Dr Eugene LeBlanc, of the Addiction Research Foundation of Ontario, told a press conference that while there are regional variations "the general world tendency has been an increasing availability on a whole variety of scales'.

There can be no meaningful talk of prevention while, at the same time, the burden on society is allowed to increase. The two acts are incompatible. Increasing consumption means, inevitably, there will be more problems, said Dr LeBlanc.

"At some point we are either going to level off because we have reached the maximum level of damage that can occur or society is going to decide that the price is too high."

Alcohol drinking is fun for many people and those who are actually alcohol casualties are in the minority. However, there are speed limits on the roads because of the need for some sort of basic standard.

"The majority has an enlightened self-interest in allowing some compromise with respect to their freedom of action with the payoff being in real dollars and in terms of the quality of life. These are not scientific decisions but public and political decisions."

Criminal stigma faces alcoholic

MOST ALCOHOLICS will never receive early help until the criminal stigma is removed from drunkenness.

And so far, most members of the public, and most politicians and professionals, exhibit studied indifference, charges Dr David Pittman, a pioneer in establishing North America's first detoxification center for police-case alcoholics.

While mental illness was taken out of the criminal province generations ago, in many states the alcoholic is still marked as a criminal, added Dr Pittman, professor of sociology and director of the Social Science Institute at Washington University, St. Louis.

"We still have the public drunkenness case within the criminal justice system and being incarcerated—serving, in many cases, life imprisonment on the instalment plan," he said.

Despite efforts to bring about the decriminalization of the public drunkenness offence, in 1974 approximately two million Americans were arrested on exactly this charge.

Most victims are sent to jail cells "to languish, sometimes without medical attention, for the simple offence of being publicly drunk; and without jailers, in some areas, taking the most elementary precaution of removing belts from those arrested," Dr Pittman continued.

Because of the associations, "is there any wonder individuals still find it a very stigmatized condition and are unwilling to recognize it as a problem in its early stages because of its intimate connection with the criminal justice system itself?"

Those with an alcohol problem develop a protective response of denying their illness, and this becomes part of the illness itself. For many people in public life, great steps are taken to conceal their problem.

Dr Pittman said a uniform act is pending in many states that would remove public intoxication from the criminal code. It provides for victims to be taken into protective custody and given emergency detoxification or other necessary medical treatment.

Some states have already enacted the law, but in turn the attitude has been "we are all in favor of doing away with this onerous and heinous law but we are unwilling to appropriate any funds for the implementation of the law," he added. Honorable exceptions have been Florida, Minnesota and Massachusetts and such cities as St Louis, Kansas City and Greensboro, North Carolina.

Dr Pittman said even those who do research in alcoholism and work in terms of early prevention and intervention are handicapped by an attitude of benign tolerance instead of full acceptance.

One of his great goals is "to take the research findings out of the laboratory or from the sociologist and to try and apply them to the community in terms of social reform and social change".

The way can be difficult. When he set up the first American detoxification center in St Louis, resistance from professional groups was "astronomical". Even among social workers and doctors, the general attitude was that it allowed "a night of debauchery followed by breakfast in bed.

"There was no comprehension at all of the problem."

Many doctors are still lax about dealing with the problem as part of a patient's history and most medical schools do not even make methods of identifying an alcoholic in the earliest stages, part of the regular curriculum.

Many facilities for alcoholics are not available under mental health programs because many psychiatrists and other medical personnel have more esoteric concerns such as schizophrenia and manic depressive diseases. Social workers have even been removed from alcoholic units because they are needed for "sicker patients".

The whole thrust of the decriminalization movement "is to try once and for all to remove the criminal label from alcoholism," said Pittman.

"Unless it is removed from the denizens of skid row and the lower income white or the ghetto dweller in the black community, we cannot expect it to be admitted in the upper income groups."

David Pittman

West Germany launches anti-alcohol campaign

By JOHN DORNBERG

BONN—Mounting consumption and growing abuse have persuaded the West German government to launch an extensive anti-alcohol campaign.

It calls for widespread dissemination of educational materials, possible restrictions on alcohol advertising, and government-sponsored anti-alcohol advertising.

The move follows a recent conference of experts from state and federal ministries of health and social welfare which disclosed an alarming level of alcoholism and alcohol abuse.

According to federal government officials, there are 600,000 alcoholics in the Federal Republic—approximately 1% of the total population—plus an additional 600,000 "problem drinkers".

Only 3% of the country's adult population is totally abstentious, according to the conference report.

"Misuse of alcohol and resultant disease," the report said, "have in recent years reached a level that is causing concern. Facilities for treating the mentally ill tend increasingly to be abused because they have to deal with a growing number of alcoholics."

The anti-alcohol drive will be headed by Manfred Franke, a senior official in the federal ministry of health, who is in charge of the ministry's narcotics and alcohol abuse department.

Franke contends the principal difference between alcohol and proscribed narcotics is that alcohol offers a legitimate form of intoxication with a strong element of social appeal and grace when consumed in moderation.

He plans to call on advertisers to moderate their claims, if not to stop advertising alcoholic beverages entirely.

Although the influence of advertising should not be overrated, he said, it does influence the undecided and when alcohol is made to appear attractive in advertisements it induces many to drink who otherwise might not.

Opinion researchers, working on government contract, have determined, for example, that the type of advertisements with which brewers, distillers, and wine merchants push their products have an especially detrimental effect on impressionable youth.

In West German advertisements, drinkers are depicted as musclemen and shapely women, as worldly, urbane, and cosmopolitan. The locations in which they are seen are not lonely rooms but romantic holiday resorts, sunswept beaches, and plush hotels.

Alcohol advertising stimulates the yearning for exotic far-away places, for adventure, for glamor.

Ads for whisky—scotch, bourbon and Canadian rye—are laced with anglicisms that appeal to the desire for urbanity. Germans are encouraged "zu trinken *on the rocks* ". The connoisseur asks "fuer einen *long drink* ". Whiskys are invariably "*mild*" "*soft*" or "*rare*".

Canadian Club, in particular, has been running a full-color campaign in West German magazines stressing that it is the drink of the new, young, forward looking generation.

Cognacs are invariably sunripened, beers are always cool and foamy, and wines sparkle in the glass.

One approach being considered by the ministry of health is a counter-campaign in which the other side of alcohol is to be depicted—the lonely person drowning his sorrows in a sleazy bar or a dreary rented room.

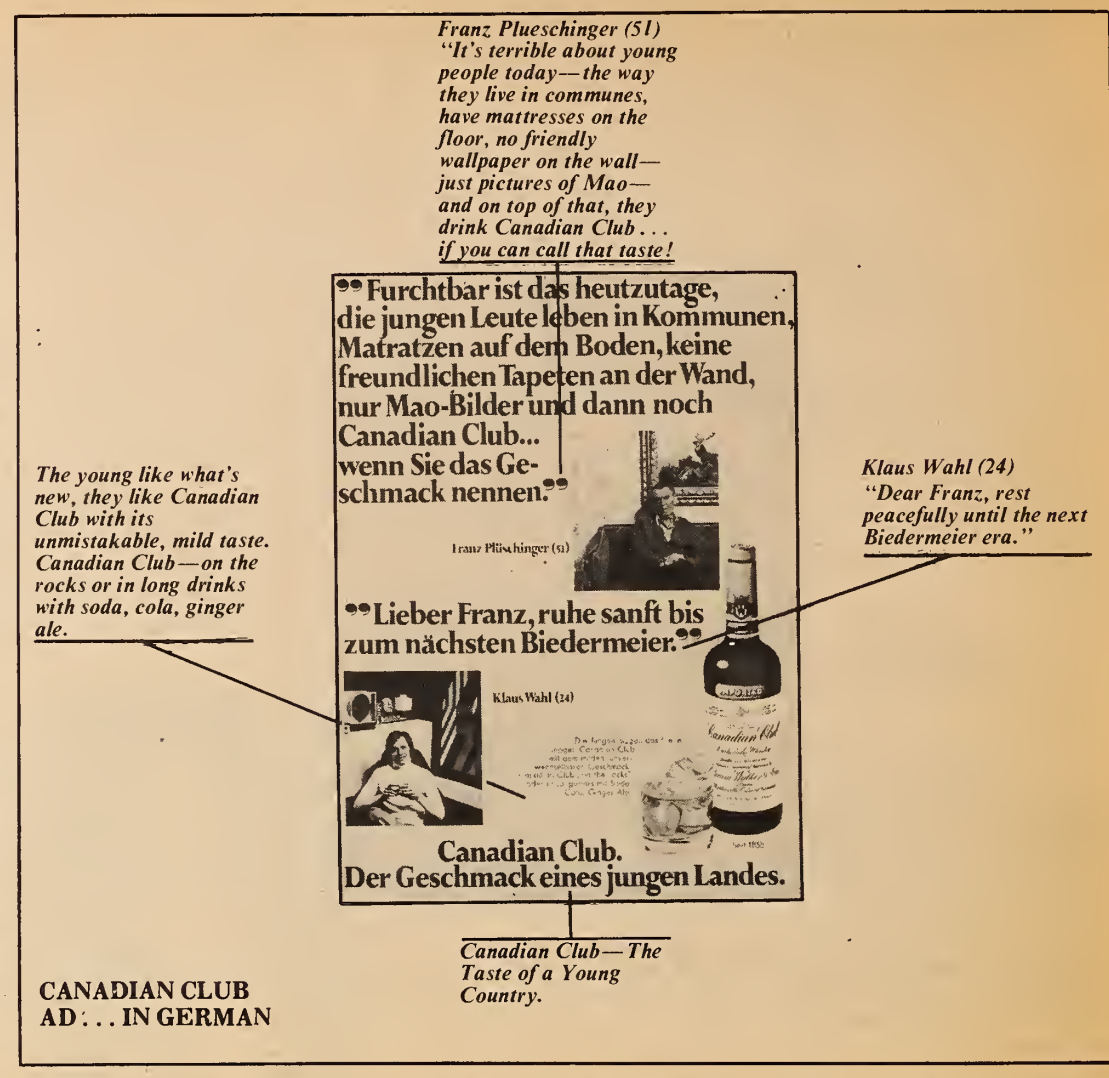
The emphasis will be on the negative aspects of drinking and how alcohol whittles away at the very social standing it promises.

Material will be prepared for distribution to schools so as to warn students of the dangers of excessive drinking and, if it is not possible to persuade them to abstain, at least to make them moderate, reasonable, social drinkers.

One suggestion under consideration, is to offer tax relief to restaurants, taverns and discotheques that do not serve alcoholic drinks, especially those that cater to young people.

The campaign will call for tighter enforcement of laws which prohibit the sale of alcoholic beverages to minors under 18 years. Though present regulations call for fines against innkeepers who serve to minors, there are no provisions for withdrawal of licences.

Another problem is how to prevent minors from obtaining alcoholic beverages from vending machines which dispense not only wine and beer but spirits as well.



CANADIAN CLUB AD . . . IN GERMAN

Drinking-driving behavior

More research needed: BMA

LONDON—A distinguished British Medical Association panel has advised the government's committee of inquiry into drinking and driving that there must be more research into adverse factors affecting driver behavior before more effective means of intervention can be devised.

The panel, under Professor Sir Edward Wayne, (former Regius Professor of the Practice of Medicine at Glasgow University), notes in its report that road accidents are now second only to malignant and cardio-vascular disease in terms of loss of expectation of life, and are of outstanding importance in terms of their contribution to the pool of permanent incapacity in the community.

It recommends roadside surveys should be performed to obtain information on the drinking and driving habits of the driver population and that the role of legislation in providing countermeasures should be reviewed with three groups of drivers in mind. These are:

1. Moderate experienced "social drinkers"—i.e. those who have moderate control over their drinking and are receptive to appropriate publicity about the dangers of drinking and driving. (The panel considers that in spite of the marked increase in alcohol consumption in Britain in the past decade, this group did not often exceed a blood alcohol concentration in excess of 0.08% when driving);

2. Young drinking drivers—i.e. those inexperienced at driving under the influence of drink, a group the panel regards as of great importance. (Between 1966 and 1973, there was a 30% increase in convictions for drunkenness unrelated to driving, under the age of 18. The proportion of drivers in this age group with a blood alcohol concentration exceeding 0.08% killed in road accidents has more than doubled since 1968);

3. Problem drinkers and alcoholics—i.e. those no longer in adequate control of their drinking and not receptive to publicity which might be appropriate to social drinkers.

The panel says there is reason to believe the publicity campaign which accompanied the 1967 Road Traffic Act was successful in persuading most drivers it would be dangerous to drive after excessive drinking and that there was a high chance of being caught if they did.

• **British Medical Association Evidence to the Government Committee of Inquiry into Drinking and Driving; British Medical Association, Tavistock Square, London WC1H 9JP.**

Hong Kong study

HONG KONG—The United States and Hong Kong are to collaborate on a major new study of the use of acupuncture in the treatment of drug addiction.

The study will be performed in Hong Kong by the Hong Kong Society for the Aid and Rehabilitation of Drug Addicts (SARDA) in cooperation with the National Institute of Drug Abuse (NIDA), Washington.

The preliminary announcement was made at the recent annual meeting here of SARDA by chairman Brook Bernacchi, QC. Final arrangements are expected to be announced within the next few weeks.

"The potential value of Hong Kong in contributing to international research on narcotic addiction is gaining prominence because the great majority of our drug dependents are addicted to a single drug, be it heroin or opium, and unlike their counterparts in America and Europe, few are poly-drug abusers," said Mr. Bernacchi.

This fact, he said, "helps to isolate variables in clinical observation".

The study will be aimed at further documenting the value of acupuncture with electric stimulation in alleviating withdrawal symptoms, reducing the craving for narcotic drugs, and preventing relapse. It will be under the direction of Dr. H. L. Wen, head of neurology, Tung Wah Hospitals of Hong Kong.

It was Dr. Wen's original study of 40 cases of drug addiction successfully treated by acupuncture (**The Journal**, June, 1973) that aroused world wide interest in the possibility of treating withdrawal symptoms, and possibly even the craving for drugs, by electro-acupuncture.

Since that study, Dr. Wen has become chairman of SARDA's research program and has continued limited experimental work in the use of acupuncture in treating drug dependents.

Around the world

"BOLELSHCHIKS"

Drunken louts, foul-mouthed boors, greasy scalpers and even female groupies are penetrating Moscow spectator sports in disturbing numbers says Komsomolskaya Pravda, the Communist Youth League paper. While most of the fans are serious spectators, the increasing numbers of "Bolelshchiks" (derived from "to be sick") is vexing Soviet authorities. One beer drinker gave this reason for attending a hockey game: "Suppose I tell my wife I am going to a beer bar. She won't let me. But, if I show her a ticket to a game, that's something else. It's like a pass."

SPANISH BREATHALYZED

All Spanish cities with populations beyond 100,000 will give breathalyzer tests to suspected drunk drivers. The driver has the right to refuse the test. However, such refusals will be considered as pointing toward guilt by judges who consider these cases. The fines will be $80.

CHILD ABUSE

Tranquillizers can turn parents aggressive and make them batter their children, according to doctors at a hospital in Oxford, England. They say the way the drugs are used has "major implications" in prevention and treatment of child abuse. In a recent issue of the British Medical Journal, the Park Hospital for Children team says a high proportion of parents in families referred for actual or threatened child abuse are taking drugs, most commonly Librium and Valium, as well as various anti-depressants.

GERMAN YOUTH

An estimated 100,000 young West Germans, often as young as 10-years-old, are becoming addicted to alcohol. "A generation of alcoholics is growing up which will present the nation with serious problems," one scientist said. According to the head of one working group trying to combat misuse of drugs and alcohol: "More than half of the 12- to 14-year-olds have already tasted alcohol and a quarter of them drink regularly". There have been cases of attempted rape by 11-year-olds under the influence of drink, said an one official.

LIQUOR ADS PROHIBITED

A meeting of Colombian State Ministers of Housing has urged the federal senate to adopt a law banning liquor advertising. In addition, the ministers recommended advertising be banned in all foreign magazines circulated in the country. No new brands of liquor should be allowed to appear on the market without government approval, and all liquor should be strictly labelled to guard against adulterations.

GERMAN ROADS

Stiffer drunk-driving laws in West Germany have resulted in a pronounced reduction of road accidents caused by alcohol, according to the German Automobile Club (ADAC).

Nursing home patients in "chemical strait jackets"

MANY ELDERLY patients in United States nursing homes "may often actually suffer setbacks in physical well-being because of poor management or worse, of prescription drugs given to them".

This is a main conclusion of a report by a Senate subcommittee on use of drugs in the country's 23,000 nursing homes.

The report is second in a series of nine planned by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging. The subcommittee's introductory report, issued last November, said half of the existing U.S. nursing homes offered substandard care.

The paper on drugs cites these among its "major points":

• The average yearly drug bill of a nursing-home patient is $300 compared to an average of $87 for other elderly people. The average nursing home patient takes four to seven different drugs daily.

• "Most disturbing" is what the report calls "ample evidence that patients are given tranquillizers to keep them quiet and to make them easier to take care of"—often those patients with the best chance for rehabilitation.

• Systems for distributing or administering drugs to patients are generally "inefficient and ineffective" with the result that 20% to 40% are "administered in error" and there is a "high incidence" of adverse reactions.

• "Kickbacks", averaging 25% of the charge, are "widespread" as are similar abuses such as supplying out-dated drugs and billing for non-existent prescriptions.

The report claims management of drugs is often the responsibility of untrained personnel and cites the danger of drug-dependence or addiction among patients receiving drugs over a long period of time. It also notes nursing home patients were used for experimental drug research, raising the question of whether patients were capable of giving "informed consent".

It cites as "perhaps the most common and most devastating consequence" the over-use of tranquillizers as "chemical strait jackets" to make patients less trouble to care for.

The report recommends "strong and immediate measures" to improve the distribution of medication. It also calls for enforcement of existing regulations, a "concerted effort" to correct abuses by nursing-home administrators, and greater vigilance by federal agencies.

A liberal outlook

Tough N.Y. drug laws challenged

By DAVID ZIMMERMAN

NEW YORK—Dents have begun to appear in New York State's tough legal front against drug use.

Some of the inroads reflect the more liberal outlook of the new, Democratic governor, Hugh Carey. Others result from court scrutiny of the stringent new state law that went into effect 18 months ago.

Governor Carey said recently in Albany he is considering an end to criminal penalties for possession of small amounts of marijuana. This "does not mean legalization," the governor said.

Rather, Mr. Carey favors fines, or mandatory referral of persons arrested for possession of marijuana to drug treatment clinics.

Reforms are needed, he said, because refusal of police and judges to enforce anti-marijuana legislation had made mockery of the law.

Judges, he noted, are dismissing marijuana cases because of the severity of the penalties, while the police, particularly in New York City, simply are not arresting people with small amounts of marijuana in their possession.

Liberalization of marijuana laws would require new legislation. The State Assembly, controlled by Democrats, is expected to welcome it, but the Republican-dominated Senate might oppose it.

In court, in New York City, a State Supreme Court justice, Leon Polsky, last month declared unconstitutional the life term for sale of or possession of methadone that is mandated by the tough Rockefeller drug law.

He said he could "conceive of no rational basis" for the law's treatment of one legally obtained dose of methadone as severely as possession or sales of large amounts of heroin or other illicit substances.

If Judge Polsky's decision is upheld, penalties for methadone possession and sale would become misdemeanors, punishable by no more than one year in jail.

"Almost all of the pending methadone sale cases involve former heroin addicts who have sold a portion of their take-home supply and 'stretched' the balance to cover their own needs," the judge said.

"The seller of his own clinic-supplied methadone (thus) is limited, at the maximum, to two or three $10 sales a week."

The city's special narcotics prosecutor has not said whether he will appeal Judge Polsky's decision.

The Rockefeller Law's harsh penalty for heroin use and possession disturbs at least one judge, Andrew Celli of Rochester, N.Y. He called the law, with its provision for a mandatory life sentence for possession of an ounce or more of heroin, "a statute without mercy," which "offends the conscience of the court and . . . the principles inherent in our Constitution."

Judge Celli made the statement last year in announcing he would sentence a man convicted for possession of heroin under the State's former narcotics statute, which specifies a maximum penalty of 15 years, and sets no minimum, rather than under the Rockefeller Law, which mandates a one year to life sentence, and lifetime parole following release.

Drugs, increased violence linked

By MANFRED JAGER

WINNIPEG—Illegal drugs and their traffic contribute to other kinds of crime as well, according to Inspector Ken Johnston of the Winnipeg Police vice squad.

"The hold-ups, muggings and robberies we are now suffering from in this community are largely due to the increased use of drugs," Insp. Johnston told a chemical abuse seminar here sponsored by the Canadian Council of Christians and Jews.

His remarks are reminiscent of those made recently by Superintendent C. A. J. J. Philion, the officer commanding the Moncton, New Brunswick, detachment of the RCMP.

Supt. Philion blamed increasing violence in that east coast city on illicit drugs.

Insp. Johnston said addicts shoplift thousands of dollars worth of goods daily, forcing stores to raise prices to recoup the losses.

"Stores don't absorb the loss, they put the prices up. They can't absorb the loss and neither can the insurance companies.

"A great deal of the economic downturn is due to drug use."

Insp. Johnston said he opposes the legalization of marijuana.

"With the permissive society we're in today—the legalization of homosexuality, the acceptance of pornography, the talk of legalizing gambling and bookmaking—with the talk of legalizing drugs you're going too far.

"The Winnipeg drug scene is a ripoff, keep it that way." If drugs were legalized, far more would be used than are being used now, he said.

Insp. Johnston criticized the LeDain Commission Report for urging the reduction of penalties for possession of small amounts of marijuana.

"Surely we're not supposed to take this seriously," he said. He said he attended hearings of the LeDain Commission in Winnipeg and saw three "known drug traffickers" speak. "These people spoke on your behalf."

Drug use in Winnipeg is on the increase, Insp. Johnston told the seminar.

He said in an 18-month period spanning 1971 to 1973, police arrested 320 persons for cannabis possession. In the first 10 weeks after Winnipeg police forces were amalgamated last year, 340 arrests for the same offence were made.

The police inspector called for Manitoba legislation to make glue-sniffing illegal.

"Last Monday night we arrested 24 juveniles in the Inner City. Twenty were arrested for glue sniffing. But there's no law against glue sniffing, so we charge them with sexual immorality or a similar vice."

Unseen dangers

WINNIPEG—There are unrecognized dangers in the use of prescription or over-the-counter drugs, a Winnipeg pharmacist told a chemical abuse seminar here sponsored by the Canadian Council of Christians and Jews.

"You hear about intentional abuse of drugs, or buying a dime bag of grass, or spiking horse, or sniffing coke," said Laurie Johnston.

"But, you don't hear about the square johns who pop a couple of goofballs with a drink and get stoned out of their heads."

He noted five potential sources for the misuse of legally available drugs:

• The physician who may be too busy to realize the number of the drugs he has prescribed to one patient, or to explain carefully why a drug is being prescribed.

• The patient who may be too casual in using the drugs because he assumes they are not harmful because the doctor prescribed them.

• The pharmacist who may be too casual in distributing drugs without checking past prescriptions.

• The failure of the patient to recognize that alcohol can cause serious side effects if mixed with prescription drugs.

• The lack of awareness that different drugs used at the same time may cause negative reactions, altered perception, or death.

'Key to better life' advertising banned in P.Q.

By DOROTHY TRAINOR

MONTREAL—Tough new regulations in the Province of Quebec covering advertising of alcoholic beverages prohibit the promotion of drinking as a key to a better life.

Announced by Justice Minister Jerome Choquette, the 13-point regulations forbid the portrayal by brewers or distillers of alcohol consumption as "directly or indirectly' associated with either social or athletic success.

The regulations cover all publicity media, including billboards, and refer to beer, wine, cider and spirits. Present advertising campaigns are permitted to continue until contracts expire or until January 1, 1976. No new advertisements may be introduced in the interim.

Some of the important new restrictions are:

• Alcoholic beverages must not be used directly or indirectly to promote individual or group popularity.

• They must not be used to promote social prestige, business success or as an aid to athletic performance.

• They cannot be used to illustrate the need for a persons's participation in activities.

• They cannot be used as an example of a possible solution to personal difficulty.

• Public figures, especially in sports and the arts, many not endorse alcoholic beverages.

• No advertisement may be used to promote drinking alcoholic beverages in general, and especially by minors.

• No manufacturer of alcoholic beverages may display its name on sports equipment except for teams of its own employees.

Letters to the Editor

Negative conclusions

Sir:

I read with interest what would be best called The Frustration Issue of The Journal (October 1974) and agree with the following negative conclusions:

1. Jail time does not deter the drinking driver.
2. The suspension of the driver's licence of the drinking driver keeps the problem drinker off the road with the same regularity as sending a nasty note home to his or her mother.
3. The breathalyzer is a waste of time in better than 95% of the cases and constitutes an additional penalty not contemplated by normal drunk driving laws.

In my 18 years of the practice of law, I have more or less specialized in driving offences and have defended probably close to 25,000 individuals charged either directly or indirectly with over-consumption of alcohol.

Although I normally don't believe that an alcoholic such as myself has more insight in the dynamics of the drunk, my conclusions hereafter set forth were arrived at prior to my alcoholism recovery and confirmed by hard data thereafter.

The suspension of the driver's licence as a deterrent is nonsense, experientially, and creates a different type of criminal, e.g. driving while licence suspended, with the attendant lack of insurance.

My office very often would appear to be a Twelve Step table with all sorts of literature on alcoholism and attendant mental health problems. More often than not I find that the suspension, particularly of the alcoholic's driver's licence, stands in the way of his recovery and produces a negative effect. Many of the laws requiring the drinking driver to take a breathalyzer test have as a penalty a six month automatic suspension for failure to comply. In well over 90% of the cases in my experience, the arresting authority doesn't need it but oft times the individual is so drunk he can't clearly understand the consequences of his failure to take it and the penalty for failure to comply is greater than the penalty for drunk driving itself, towit: Six month suspension, failure to take breathalyzer, and thirty days suspension, first conviction of drunk driving, and in the state of Washington there is no occupational driver's licence for the breathalyzer suspension.

Thus, a person can plead guilty in the majority of states to drunk driving because he is guilty and has no defence, and nevertheless be prohibited from driving for six months.

The financial burden attendant to the lack of mobility is normally so great that the drinking driver will drive and not have insurance. It has been impossible for me, even by court order, to get permission for alcoholics to drive to and from information schools, therapy, or Alcoholics Anonymous meetings. The result, except in a very few cases, is predictable, particularly for those who are trying to overcome a drinking problem.

They become more hostile towards the state, more disrespectful of authority and unless extremely dedicated to sobriety, say to hell with it, and go back and drink.

I would thus add another criticism to those who advocate stronger, more stringent penalties, that being that the penalties are in fact, in most cases, counter-productive and in many cases prohibit, practically, recovery of the individual alcoholic.

Alva C. Long
Attorney at Law
Auburn, Washington 98002

Methadone alert

Sir:

As Coordinator of a drug abuse treatment program, I am writing to alert your readers that Madison, Wisconsin does not at this time have the capability to provide methadone to anyone unless they are hospitalized.

We have had numerous visits from vacationing or visiting methadone clients who presumed that methadone would be available. Each of these visitors experienced varying degrees of frustration and discomfort when they learned no methadone was available in Madison.

We would greatly appreciate the cooperation of your readership in alerting methadone programs and clients that plans must be made for a take-home supply if travelling to Madison.

David E. Joranson, Coordinator
Dane County Comprehensive
Drug Abuse Treatment Program
Madison, Wisconsin 53703

In British Columbia

Re-organization takes its toll

By PETER THOMPSON

VANCOUVER—The executive directors of the Alcoholism Foundation of British Columbia and the Narcotic Addiction Foundation of B.C. have been fired.

The contracts of E. D. "Ted" McRae of the AF and Douglas Denholm of the NAF have been bought out by the provincial government.

The moves are part of the absorption of responsibility by the new Alcohol and Drug Commission for drug programs in the province.

Both Mr. McRae and Mr. Denholm say their contracts were bought out on generous terms.

Ted McRae is considered a founding member of the Canadian fraternity on alcholism. As head of the AF, he spent two decades enduring the disinterest in social rehabilitation of the former Social Credit government of W.A.C. Bennett.

The cash register government of the Social Credit Party was defeated more than two years ago by the New Democratic Party, elected on a platform pledge to pour money into the social malaise of the province.

And a few months ago, Mr. McCrae was asked to resign by the Alcohol and Drug Commission created by the NDP government to take over drug problems.

By a curious irony of fate, Mr. McCrae survived a regime that opposed him at almost every turn, only to fall victim to the government whose election he saw as his only salvation.

Mr. McCrae became executive director of AF in 1954, the year after it was formed, and was given a budget of $25,000, inherited by the Socreds from the budget of the previous government. Increases to his budget over the next two decades came painfully, he said.

"The government was reluctant to provide us with funds. The provincial budget under the Socreds went from $2 million to more than $1 billion while our budget went from $25,000 to the horrendous sum of $400,000 in 1973.

"Provincial revenue from alcoholic beverages skyrocketed from $5 million to $50 million and $60 million a year. Some years," Mr. McCrae said, "the increase we got was only enough to keep up with increasing costs."

The provincial government fed the AF enough to keep it alive, he said, but not enough to keep it healthy.

"When I look back I have to admit—though I hate it because it isn't very flattering—they were practising tokenism. We," Mr. McCrae said, "were the token programs."

Douglas Denholm

Ted McRae

The AF was run as a private society under the Societies Act of B.C., a favorite device of the Socreds for such agencies. Though a private organization, the AF was charged with providing a service to the entire province.

"If we did well, the government could take credit for it," he said. "And if we failed, they could absolve themselves because we were a private agency."

In spite of handicaps, Mr. McCrae said the AF did succeed in making British Columbians more aware of alcoholism.

He said he was elated when Bennett was defeated by Dave Barrett and the NDP. Mr. McCrae was out of the country at the time and didn't vote.

"I think now," he says, "it was a good thing."

Mr. Denholm became executive director of the NAF in 1970 after serving on its board of directors for about eight years.

Mr. Denholm partially attributes the increase in heroin use in B.C. today to the neglect of narcotic addiction by the provincial government while he was head of NAF. The emphasis then was on the so-called soft drugs.

"The community was almost completely polarized on the issue of drugs then.

"Almost any meeting I went to in the early 70s concerned with drugs was immediately polarized with all the hawks on one side and the doves on the other," he said.

"In the middle, the only place you can do any work, were damn few people.

"Today, it's still a bit like that but not nearly as much so. People are beginning to come into the centre."

'76 budget indicates enforcement emphasis

By OTHA LINTON

WASHINGTON—The U.S. federal budget for alcohol and drug abuse prevention, control and enforcement programs will rise for law enforcement and decline for prevention, treatment, education and research during fiscal 1975, which begins in July.

Spending proposed by President Gerald R. Ford in his February budget message would total $810.2 million for social action programs and $305.1 million for law enforcement if the Congress accepts his recommendations.

The figures represent a decrease of $63 million from $873.2 million for social action and an increase of $24.1 million from $281 million for law enforcement in the current fiscal year.

While the Congress can raise or lower the President's figures before authorizing and appropriating expenditures, indications are the drug abuse program will share the kinds of budget cuts proposed for most federal agencies.

This results from the combined impact of inflation and recession plus a feeling that addiction problems are coming under control. For example, the budget report asserts that federally-supported programs now have adequate capacity to provide treatment for every heroin addict who applies to them.

The entire $305.1 million indicated for substance abuse law enforcement is shown as directed against drugs.

The largest share, some $203.3 million, will be spent by agencies of the Department of Justice, notably the Drug Enforcement Agency, the Law Enforcement Assistance Administration and the Bureau of Prisons. Justice will spend an additional $38.8 million on other addiction related activities.

The consolidated budget figures cover all activities by all federal agencies. Within the law enforcement category, totalling $305.1 million, the Treasury Department will spend $62.1 million, mostly through the Customs and Immigration Services to try to block illegal drug traffic. The State Department will contribute $37.8 million to the same effort. The Department of Defence and the Department of Agriculture round out the total with $1.9 million between them for enforcement.

The largest agency budget will be $553.8 million for programs within the Department of Health, Education and Welfare.

Of this total, $363.8 million will go to the Alcohol, Drug Abuse and Mental Health Administration. The Social and Rehabilitation Service will get $144 million, the Office for Human Development will get $40.2 million, the Office of Education $1.9 million and other HEW agencies $3.9 million.

The totals will cover major federal programs in treatment and rehabilitation at $425.7 million, programs in prevention and education at $63.5 million and in research, planning and coordination at $64.6 million.

The Department of Defence will spend a total of $85.1 million in social action areas. The Veterans Administration will spend $91.3 million, the Department of Transportation $17.9 million on alcohol-related accidents on the highways, and other federal agencies $23.7 million in fiscal 1976.

Total spending in the addiction and abuse areas rose in the current fiscal year to an estimated $1154.2 million from an actual expenditure by all federal agencies of $891.9 million in fiscal 1974 which ended last June.

Feast or famine for alcohol researchers

RALEIGH, N.C.—A continual feast or famine in the allocation of money is the prime barrier for researchers in alcoholism.

"What you need if you are really going to get at this problem, which is complicated and involves so many different kinds of specialized backgrounds, is the recruitment and training of people who will make a career almost, out of trying to understand it," said Dr. Donald Goodwin, a Washington University researcher.

"And you cannot do this unless you have some prospect at least of an economic base that is better than just year by year. As it is now in this area of research you have a feast and famine situation."

Dr. Goodwin pointed out that at his own Addiction Research Center at the St. Louis university "18 months ago we were letting people go who were in alcohol studies because we just didn't have any money. Then suddenly we have money given to us and good for three years.

"But when the three years are up there is no guarantee that it will be renewed, even if we do well."

Dr. David Pittman, director of the Social Science Institute at Washington University, said the $10 million Congress has allocated for alcoholism research "is not even the cost of a Boeing 747 aircraft.

"That is a pitifully small amount of money to be dedicated in terms of basic research to one of the most serious health problems in this particular country, and also one of the most expensive health problems."

Dr. Ronald Thurman, of the Johnson Research Foundation, University of Pennsylvania, said most research dollars go into the study of the consequences of chronic over-intake of alcohol instead of going into the basic study of what leads people to over-drink.

"It is logical to conclude we wouldn't have the final stage if we understood the first stage and could arrest the process there," he said.

'Near-alcoholism' plays havoc with lives of 36 million in U.S.

By MARY HAGER

SAN FRANCISCO, CAL.—A New York alcohol expert has identified a new alcohol problem which he claims affects some 36 million people in the United States alone.

He calls it "near-alcoholism" and defines it as "an ailment which can afflict anyone living near (psychologically if not physically) an excessive drinker, or the memory of one".

"This so far anonymous alcohol problem may be even more cunning, baffling and powerful than alcoholism," said Dr Barry Leach, a research psychologist, formerly with the departments of psychiatry and medicine, The Roosevelt Hospital, New York. He was speaking here at the North American congress on Alcohol and Drug Problems.

Near-alcoholism afflicts the families, friends and work colleagues of alcoholics as well as professionals who work with alcoholics, he said.

He suggested near-alcoholics need help and attention and that their well-being should not be dependent upon the drinking behavior of someone else.

He described a survey of 2,347 non-alcoholic members of Al-Anon groups in six different states, aimed at defining the problems of the near-alcoholic.

The development of a pathologic response to alcoholism can be a rapid process, taking as little as two years, or a slow process developing over a period of as long as 28 years, he said.

The survey produced a list of symptoms characterizing a maladaptive response to alcoholism.

The earliest symptom, reported by "an amazing 89% of subjects," is embarrassment at the drinking-related behavior of the drinker.

This nearly-universal symptom is followed by an ambivalence or confusion about the drinker, the drinker's drinking-related behavior, and the non-alcoholic's relationship with the drinker, and a denial that the drinking is a disturbance, often to the point of overlooking or rationalizing it, he said.

Next on the symptom list are fear, anxiety or apprehension both about the drinker and "what will happen to me as a result of drinking-related behavior", tension in relation to the drinker, false hopes that the drinking behavior will improve, and disappointment that the drinking-related behavior exists and is disturbing, he said.

Guilt, a feeling that the non-drinker is somehow responsible for the drinking behavior, alienation from the drinker, and anger, disgust and revulsion towards the drinker, are also symptoms. So are feelings of protectiveness toward or pity for the drinker.

As near-alcoholism progresses, an obsession with the drinker's drinking behavior may develop, coincidental with feelings of rage and panic and worry about the welfare of the non-alcoholic members of the family.

This, he said, may be coupled with concern about the alcoholic's illness, a hostile reaction towards all alcoholic beverages, a deep sense of frustration, lethargy and hopelessness, self-pity or remorse.

Some may be vindictive or vengeful towards the alcoholic and totally distrust the drinker and other people as well, he said.

Outwardly, the near-alcoholic will show a decrease in independent activity, will take over some of the stereotype male roles within a family and may then withdraw, getting into frequent nagging quarrels with the drinker, Leach observed.

For about 55% of the respondents, sexual problems—usually frigidity rather than promiscuity—developed, he said. Lying, threats of walking out, hiding, or pouring out liquor to control intake, also occur, along with increased drinking by some of the non-alcoholic spouses, or frantic involvement in a job or a hobby.

Such symptoms have therapeutic benefit for the near-alcoholic who gains an understanding of his own state of health and can identify with thousands of other people, Leach said.

He suggested Al-Anon, which is "still misunderstood, underrated and under-utilized," provides the most effective treatment method for near-alcoholism.

Many of the near-alcoholism symptoms are also found among alcohologists, industrial and government officials, and in the communications media.

Embarrassment, for instance, is frequent among counsellors and therapists who explain failures by saying clients are not motivated. Entertainers also often use humor to overcome embarrassment at drinking behavior, he said.

The English-speaking, North American continent, he observed, is a "culture in which health professionals, the institutions of industry and government, national television networks, and prestigious newspapers, manifest florid near-alcoholism, responding to problem drinkers with as blatant a psychopathology as any alcoholic displays."

U.K. tobacco ban

LONDON—The British anti-smoking ginger group Action on Smoking and Health is pressing the government to impose further restrictions on the advertising of tobacco products.

At the moment, cigarette advertisements are not allowed on British television and all cigarette packets must carry a government health warning.

But ASH, inspired by the Norwegian government's stringent new measures which will prohibit all tobacco advertising from July 1975, wants to see a more thorough clampdown.

Speed users prone to premature death

By MILAN KORCOK

SPEED KILLS! Or does it?

Advocates for both sides of the argument have been both plentiful and vocal. But mostly, their convictions have rested on intuition rather than scientifically supportable fact.

Until 1966, only nine cases of death attributed to amphetamine toxicity had been reported in the world medical literature—hardly enough to support or deny the contentions of the sloganeers.

But a recent update of the world literature, and a compilation of coroners' statistics on amphetamine deaths in Ontario in 1972 and '73 promises to add some substance to the dialogue.

The report, prepared by Drs. Harold and Oriana Kalant of the Addiction Research Foundation of Ontario substantiates that the regular heavy amphetamine user is far more likely to die prematurely than is the medically-controlled or the non-user.

It indicates that the intravenous amphetamine user's chances of premature death are four times greater than are those of the non-user, which makes his chances of an untimely end comparable to those of the alcoholic or the heroin addict.

Published in the Canadian Medical Association Journal (Feb. 8, 1975), the Kalant survey focusses on 26 deaths among amphetamine users in Ontario, and comments on 42 reports of amphetamine-related deaths drawn from the world literature.

Of the 26 Ontario deaths two-thirds were of a violent nature: Seven were due to accidental violence, seven to suicide, and three to homicide. This includes erratic behaviour, paranoid ideas, overt aggression, feelings of omnipotence, and in some cases, confusion.

One case: A 22-year-old man, high on speed, shot and killed a police officer. Traced by police to a house, he refused to surrender, and shot himself in the head. At autopsy, the coroner found sclerosed veins in the forearms, foreign body granulatoma in the lungs, and chronic inflammatory cells in the portal areas of the lungs.

Toxicological examination showed the presence of amphetamine, methamphetamine, and barbiturates.

Of the 26 reported Ontario deaths there were two cases of cardiac death resulting from drug toxicity, two from viral hepatitis or post hepatic cirrhosis (complications of intravenous administration), five cases were classed as drug overdoses—three resulting from asphyxia and two from unknown mechanisms.

In 18 of the 26 cases, the Kalants reported the presence of other drugs in addition to the amphetamines. In fact, in nine cases, other drugs or toxic materials were present in such large amounts they were probably primarily responsible for death. These included carbon monoxide, MDA, alcohol, methaqualone, barbiturates, and minor tranquillizers.

Toxicological examinations, as reported in both the Ontario coroners' series and the literature survey, showed that for those cases where blood levels were defined, all but four exceeded the value of .01 mg per 100 ml, considered the therapeutic dose of amphetamine.

The Kalants also noted there is clearly a greater risk of death among regular intravenous than oral users. Of the 26 cases in the Ontario series, 16 of the deaths were known to be regular I.V. users, compared to only three who were oral users.

Despite the extremely broad medical use of amphetamines during the past few years, there are remarkably few fatalities reported among patients taking the drug under medical supervision, says the Kalant report. There are are only five such cases reported in the world literature, and three of these involved the simultaneous administration of MAO (Monoamine oxidase inhibitors).

Simultaneous administration of amphetamine and MAO inhibitors such as tranylcypromine and phenelzine is coming to be recognized as being particularly hazardous.

Of the 43 cases reported in the world literature, the Kalants indicate that there were seven clear-cut cases of death due to intracranial hemorrhage (four of these linked MAO and amphetamine), six cases of acute cardiac failure, three cases of hyperpyrexia with temperatures of the order of 109 degrees, seven cases of medical complications of intravenous injection, eight poisonings in which the mechanism of death was uncertain, and the rest were of uncertain cause.

$2 billion loss in productivity

WINNIPEG—Canada loses $1.5 to $2 billion in productivity annually because of absenteeism or reduced effectiveness of employees as a result of alcohol misuse, according to Stewart Graham, executive director of the Alcoholism Foundation of Manitoba.

Another $1.5 billion to $2 billion is used up in increased health costs, he told a chemical abuse seminar here sponsored by the Canadian Council of Christians and Jews.

Alcohol is involved in 60% of homicides in Canada, 30% of suicides, 40% of hospital admissions, 40% of family court cases, 25% of hospital admissions and 50% of fatal traffic accidents, he said.

Provincially, there are 30,000 problem drinkers who daily consume nine ounces of whisky or more or its equivalent. There are about 16,000 confirmed alcoholics in Manitoba.

"These figures increase annually," Mr. Graham said. "Alcohol abuse is more serious than all other drugs combined."

Mr. Graham said he opposed banning alcohol, or imposing restrictions on everyone just to reach the 5% of Canadians who are problem drinkers.

There are other options, he said, including controlling the number and variety of liquor outlets and the advertising of liquor, public education to develop decreased tolerance for public drunkenness, and avoiding the image of the "funny drunk". Differential taxation based on the strength of different liquors could also be employed, Mr. Graham suggested.

"We must teach people to drink in a responsible way. We can succeed where others before us have failed. We have more tools," he said.

"People are better educated. We can impart knowledge without boredom. They know their society better. The young are more humanistic."

He called for the imaginative use of modern communications techniques to create a climate where legislators can bring in controls to guide drinking habits and reduce alcohol consumption and abuse.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

Recent Advances in the Management of Alcoholism and Drug Addiction—March 1, Toronto, Ont. Information: The Director, Division of Post-graduate Medical Education, University of Toronto, Toronto, Ont. M5S 1A8.

American Orthopsychiatric Association—Fourth Annual Institute and 52nd Annual Meeting—March 21-25, Washington, D.C. Information: American Orthopsychiatric Association, 1775 Broadway, N.Y. 10019.

Postgraduate Day on Clinical Pharmacology—Antimicrobial Drugs—April 5, Toronto, Ont. Information: The Director, Division of Postgraduate Medical Education, Faculty of Medicine, Medical Sciences Building, University of Toronto, Toronto, Ont. M5S 1A8.

National Drug Abuse Conference—April 4-7, New Orleans. Information: Mr. V. Shorty Director, Desire Narcotic Rehabilitation Center, 3307 Desire Parkway, New Orleans, Louisiana 70126.

59th Annual Meeting of the Federation of American Societies for Experimental Biology—April 13-18, Atlantic City, New Jersey. Information: Mrs. T.C. Heatwole, Director, Public Information, 5110 W. Franklin St., Richmond, Virginia 23226.

First International Congress on Patient Counselling—April 21-23, 1976, Amsterdam. Information: Congress Secretariat, First International Congress on Patient Counselling, c/o Excerpta Medica Foundation, P.O. Box 1126, Amsterdam, The Netherlands.

National Alcoholism Forum—Annual Conference of the National Council on Alcoholism—April 27-May 2, Milwaukee, Wisconsin. Information: George C. Dimas, Executive Director, National Council on Alcoholism, 2 Park Avenue, N.Y. 10016.

Sixth Annual Medical Scientific Conference of the National Council on Alcoholism—April 28-29, Milwaukee, Wisconsin. Information: George C. Dimas, Executive Director, National Council on Alcoholism, 2 Park Avenue, N.Y. 10016.

37th Annual Scientific Meeting, The Committee on Problems of Drug Dependence—May 19-21, Washington D.C. Information: Executive Secretary, Committee on Problems of Drug Dependence, NAS-NRC, 2101 Constitution Ave., N.W., Washington D.C. 20418.

Institute on Crime, Justice and Heroin—May 19-June 3, London, England. Information: Dr. A.S. Trebach, Centre for the Administration of Justice, The American University, Washington, D.C. 20016.

10th Annual Conference of the Association of Halfway House Alcoholism Programs of North America, Incorporated—June 8-11, Hot Springs, Arkansas. Information: Jack Shea, Conference Coordinator, Association Office, 786 E. Seventh St., St. Paul, Minnesota 55106.

New England School of Alcohol Studies—June 8-13, University of Vermont, Burlington, VT. Information: Jan S. Durand, Coordinator, P.O. Box 11009, Newington, CT 06111.

Annual Meeting of the American Psychiatric Association—May 5-9, Anaheim, Calif. Information: Dr. W.E. Barton, Medical Director, 1700 18th Street, N.W., Washington, D.C. 20009.

First International Conference on Substance Abuse in Industry—May 6-9, Detroit, Michigan. Information: Special Programs Department, Society of Manufacturing Engineers, 20501 Ford Road, Dearborn, Michigan 48128.

21st International Institute on the Prevention and Treatment of Alcoholism—June 9-15, Helsinki, Finland. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Rutgers Summer School of Alcohol Studies—June 22-July 11, New Brunswick, N.J. Application deadline May 1. Information: Miss L. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

First Annual Deep South School of Alcohol Studies—July 6-11, Shreveport, Louisiana. Information: Sam D. Thomas, Director, Deep South School of Alcohol Studies, Centenary College, P.O. Box 4188, Shreveport, Louisiana 71104.

Triennial Refresher Course for Alumni of Rutgers Summer School of Alcohol Studies—July 13-17, New Brunswick, N.J. Information: Miss L. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

Sixth International Congress of Pharmacology—July 20-25, Helsinki, Finland. Information: Secretariat, Sixth International Congress of Pharmacology, Siltavuorenpenger 10, SF-00170 Helsinki 17, Finland.

Institute on Addiction Studies—August 17-22, McMaster University, Hamilton, Ont. Sponsored by Alcohol and Drug Concerns, Inc. Information: David Reeve, 15 Gervais Drive, Don Mills, Ont.

Third International Conference on Drug Abuse—Sept. 1-5, London, England. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Joint Meeting of the Alcohol and Drug Problems Association of North America and the Canadian Foundation on Alcohol and Drug Dependencies—Sept. 14-19, Quebec City. Information: OPTAT, 969 Route de l'Eglise, Quebec 10e, P.Q. G1V 3V4.

First National Conference on Occupational Alcoholism and Drug Abuse—Nov. 17-20, Ottawa, Ont. Jointly sponsored by Humber College and Addiction Research Foundation. Information: Jim Simon, A.R.F., West Toronto Branch, 4143 Dundas St. W., Toronto, Ontario M8X 1X2.

International Conference on Alcoholism and Drug Dependence—Oct. 26-Nov. 1, Sao Paulo, Brazil. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Positions Available

PLAN NOW TO ATTEND SME'S 1st International Conference on Substance Abuse in Industry

The First International Conference on Substance Abuse in Industry will take place May 6-9, 1975 at Cobo Hall in Detroit, Michigan. This most important and timely program will discuss the problem of alcoholism and drug abuse in the work setting. The subject will be considered as a cost to industry, and will cover practical approaches relating to the reduction of costs and the return of valuable employees to productivity.

WHO SHOULD ATTEND:

- Personnel Directors
- Corporate Medical Personnel
- Labor Representatives
- Industrial Relations Consultants
- Directors of Employee and Industrial Relations
- Occupational Program Consultants
- Managers of Manpower Development and Training
- Private and Public—Substance Abuse Agency Personnel

IMPORTANT QUESTIONS THIS CONFERENCE WILL ANSWER

The Cost To Industry:
- What costs are incurred as a result of the alcohol impaired and drug dependent employee?
- Can costs be reduced?
- Can costs be accurately measured?
- To what extent does the troubled employee effect corporate profitability?

Nature of the Problem:
- Who is the alcohol or drug dependent employee?
- What physiological, psychological and sociological factors result in an employee becoming alcohol or drug dependent?
- Should industry play a role in the identification and rehabilitation of the troubled employee?

Development of a Control System:
- What is the cost to implement a troubled employee program?
- How does such a mechanism function?
- Who implements this program?
- What role does the labor union play in the conduct of an occupational program?
- Can the system be evaluated?
- What options are there in selecting an in-plant control system?
- What is the net gain from such a program?

Important Considerations:
- How and what community resources are available for treatment of the troubled employee?
- What type of medical insurance will be required for such a program?
- Is special training of supervisory personnel necessary?
- What resources are available to the company who wishes to develop a program?
- How is a medical-behavioral control system sold to top management?

PROGRAM STAFF:

FERN E. ASMA, M.D.
Assistant Medical Director
Illinois Bell Telephone Company

ROWLAND L. AUSTIN, Director
Alcoholism and Drug Abuse Programs
General Motors Corporation

BILL COMBS
Alcoholism Program Director
District 141
International Association of Machinists and Aerospace Workers

JAMES L. FRANCEK
Director of Center for Counseling and Guidance
Kelsey-Hayes Company

WILLIAM J. GRAVES
Manager, Special Projects
National Clearinghouse for Alcohol Information

PAT GREATHOUSE
Vice President
United Auto Workers

PAUL JOHNSON
Counselor, Co-Therapist
Lafayette Clinic

AJEET S. KANG
Assistant Manager
Business Research Department
Blue Cross of Michigan

WILLIAM L. KEATON
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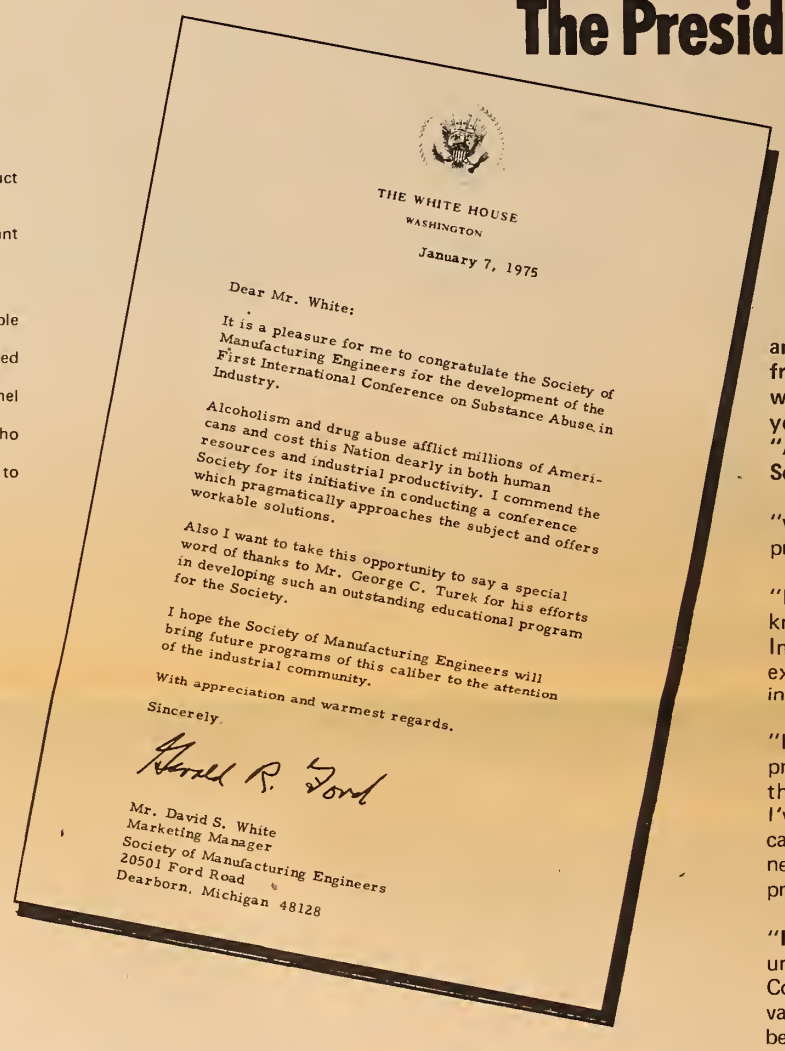
PHYLLIS E. TUTTLE
Corporate Drug and Alcohol Abuse Program Coordinator
Ford Motor Company

WILLIAM W. WINPISINGER
General Vice President
International Association of Machinists and Aerospace Workers

A Comment from The President...



THE WHITE HOUSE
WASHINGTON

January 7, 1975

Dear Mr. White:

It is a pleasure for me to congratulate the Society of Manufacturing Engineers for the development of the First International Conference on Substance Abuse in Industry.

Alcoholism and drug abuse afflict millions of Americans and cost this Nation dearly in both human resources and industrial productivity. I commend the Society for its initiative in conducting a conference which pragmatically approaches the subject and offers workable solutions.

Also I want to take this opportunity to say a special word of thanks to Mr. George C. Turek for his efforts in developing such an outstanding educational program for the Society.

I hope the Society of Manufacturing Engineers will bring future programs of this caliber to the attention of the industrial community.

With appreciation and warmest regards.

Sincerely,

Gerald R. Ford

Mr. David S. White
Marketing Manager
Society of Manufacturing Engineers
20501 Ford Road
Dearborn, Michigan 48128

and comments from registrants who attended last year's SME sponsored "Alcoholism in Industry" Seminar, , ,

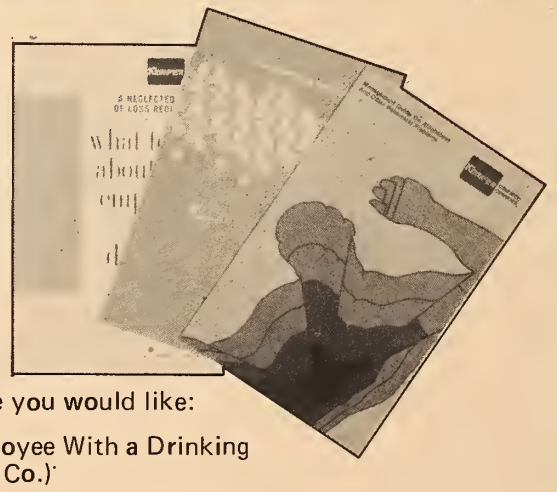
"well organized and presented . . ."

"Informed and knowledgeable speakers. Impressive examples of existing effective industrial programs . . ."

"I have attended many programs on the subject through the eight years I've been in the field. I can truthfully say I have never been to a better program . . ."

"I came to this meeting under "Constructive Coercion" and picked up valuable information beyond my expectations"

Send for a Free Brochure dealing with Substance Abuse in Industry, *Prepared as an aid to show business and industry how excessive costs can be reduced and valued employees retained through updated policies and procedures which utilize current knowledge about alcoholism and drug abuse in the work setting.*



Please check which Free brochure you would like:

- ☐ What to Do About the Employee With a Drinking Problem (Kemper Insurance Co.)
- ☐ What About Drugs and Employees? (K. I. C.)
- ☐ Management Guide on Alcoholism and Other Behavioral Problems (K. I. C.)

Name/Title _____

Company _____

Address _____

City/State/Zip _____

☐ **YES! I would also like additional details about the upcoming First International Conference on Substance Abuse in Industry.**

REGISTER NOW 1st International Conference on Substance Abuse
May 6-9, 1975 • Cobo Hall • Detroit, Michigan

MAIL TO: Special Programs Department
Society of Manufacturing Engineers
20501 Ford Road
Dearborn, Michigan 48128
313/271-1500, Ext. 54

Confirming Notice and Housing Information will be sent to you upon receipt of this registration form.

YES! Please register the following for the "First International Conference on Substance Abuse in Industry. Enclosed is a check or company purchase order, as indicated:

Organization Name and Address (include zip):

_____

_____

Registrant Name and Titles:

1st _____

2nd _____

3rd _____

$125.00 Registration Fee

☐ Bill Me ☐ Bill My Company ☐ Purchase Order No. _____

Make Checks Payable to SME

REGISTRATION FEE INCLUDES: Banquet, Daily Lunches, Coffee and Coke Breaks and Notebook of Materials.

The Journal

VOL. 4 NO. 4 | PUBLISHED MONTHLY BY THE ADDICTION RESEARCH FOUNDATION | TORONTO APRIL 1, 1975

Technique may prevent cirrhosis

TORONTO—Scientists at the Addiction Research Foundation of Ontario, and the department of pharmacology, University of Toronto, are hopeful they may have discovered a new medical technique to prevent alcoholic liver cirrhosis.

The technique, now undergoing clinical trials, involves using the anti-thyroid drug propylthiouracil (PTU) to reduce the speeded-up metabolism of liver exposed to heavy amounts of alcohol.

This increased oxygen demand cannot always be met by the liver's blood supply. The result of such oxygen deficiency is cellular damage leading to alcoholic hepatitis, which in a high proportion of cases develops into cirrhosis.

Professor Yedy Israel, principal investigator, indicated that if the clinical trials at the ARF Clinical Institute are as successful as the animal trials,

Yedy Israel

By MILAN KORCOK

it should be possible to halt the cellular damage associated with alcoholic hepatitis in humans.

This should facilitate quicker and easier treatment of this disease, and sharply reduce the number of hepatitis and cirrhosis deaths, he said.

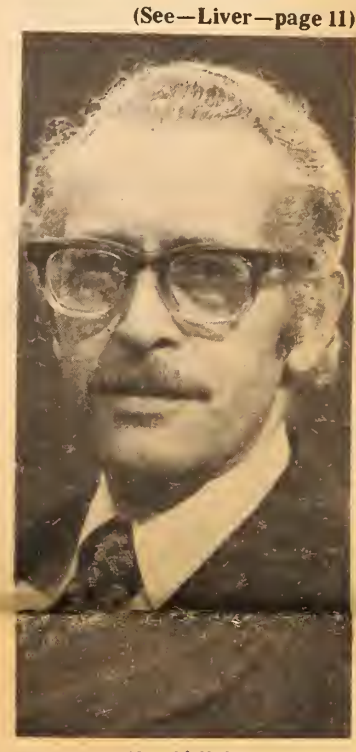
Dr. Israel is an ARF scientist and professor of pharmacology at U of T. Dr Harold Kalant, chief co-investigator, is associate research director at the ARF and professor of pharmacology at U of T.

The implications of the work are significant. In 1973, more than 2,500 Canadians died of liver cirrhosis. In Ontario in 1972, there were 921 deaths from the disease and scientists estimate that 60% of liver cirrhosis deaths in the province are attributable to heavy alcohol consumption.

In countries where the rate of alcoholism is even higher, the number of deaths from the disease is that much greater. In France and Chile, for example, both of which have high alcohol consumption, almost 90% of liver cirrhosis deaths are attributable to alcohol consumption.

The current studies can be traced back 13 years when Drs. Kalant and Israel, began investigating mechanisms by which alcohol affected certain chemical reactions in the brain.

(See—Liver—page 11)



Harold Kalant

'Profound treatment implications'

TORONTO—A technique developed by Addiction Research Foundation of Ontario and University of Toronto scientists has been described as "potentially the most exciting development in the field of alcoholism in the past 25 years".

"This work has profound implications for the future treatment of liver disease throughout the world," H David Archibald, executive director of the ARF, told *The Journal*.

Moreover, said Mr Archibald, if the clinical trials bear out the findings of the animal research, the work will have immense implications in terms of health costs.

"In many countries, liver disease is an enormous contributor to overall health costs [illegible]

"The potential net savings in terms of health delivery costs will be enormous compared with the amount invested in this research," he said.

Mr. Archibald said the work provides "a clear example of the importance of supporting well-formulated basic research".

"I fully recognize that from the perspective of the scientist, more investigation is needed. The specific instrument to treat alcoholic cirrhosis in [illegible]

"Nevertheless, in my view, the work to date has very significant implications for the future treatment of that disease and possibly other liver disorders and should be viewed in that light."

Cannabis witnesses agree

Decriminalization must not imply endorsement

OTTAWA—Though testimony before the Senate committee studying cannabis laws remains divergent, most witnesses seem to agree on one critical point: that decriminalization of marijuana must not be interpreted as an endorsement of the drug.

Effectively discouraging use of marijuana, while removing its simple possession from criminal sanction is likely to be a difficult task, but as the senators have been repeatedly told, it is imperative.

Dr. Thomas E. Bryant, president of the Washington-based Drug Abuse Council and prominent advocate of legal reform in respect to marijuana, agrees that "when used heavily (such a drug) can injure the user psychologically, if not physically".

"Marijuana can be harmful to the individual, especially taken in high dosages over an extended period of time. This is true of almost any psychoactive substance we put into our body.

"(But) I believe firmly that current public policies toward marijuana are counterproductive, causing needless, deep disruption in society," said Dr. Bryant.

Dr. Andrew Malcolm, Toronto psychiatrist and author of several books on drugs and states of intoxication, has been openly critical of many bodies for their advocacy of decriminalization.

Yet as different as his views are from those of Dr. Bryant, Dr. Malcolm agreed that the marijuana law as it stands under the Narcotic Control Act is "clearly disharmonious with the age we live in."

"We must act accordingly, and diminish the weight of the law without for a moment giving the impression that this is being done because we have come to look less seriously upon the consequences of using the drug.

"We must not be lulled into the briefly comfortable understanding that it is the law that is the cause of all our trouble."

He noted that the cannabis bill, which is designed only to ease the legal pressures associated with the use of cannabis, will fail grievously "if its passage is not accompanied by an immense educational effort."

In substantiating a need for public education about marijuana, witnesses Bryant and Malcolm ran a somewhat parallel course. But when discussing the specific effects of the drug, they clearly saw things differently.

Citing evidence of amotivational syndrome, the possibility of organic and irreversible brain damage, suppression of testosterone, chromosome breakage, and personality disturbance, Dr. Malcolm said that such potentially harmful effects will undoubtedly take time to resolve.

He noted that there has really only been a decade or two of true clinical and scientific study of the effects of cannabis on humans.

"In the meantime, there is no reason whatever for us to be complacent," said Dr. Malcolm.

Many proponents have tried to make the case that the drug is "soft" and relatively benign said Dr. Malcolm. Yet, medical evidence suggests that cannabis should be of increasing concern as

(See—Cannabis—page 3)

Codeine shortage downplayed in U.S. government turnabout

By LYDIA WOODS SCHINDLER

WASHINGTON—In something of an about-face, U.S. medical and government officials have joined forces in downplaying the "critical shortage" of codeine.

At the same time, the government has unofficially but explicitly curbed its opposition to poppy cultivation in Turkey.

At a symposium here on The Supply of Opium for Medical Use, convened by the American Medical Association, experts agreed there is no immediate danger of running out of codeine.

"If shortage is defined as the denial of a patient's requirement, then there has not been a shortage," declared Ambassador Sheldon B. Vance.

Ambassador Vance, the state department's senior adviser and coordinator for international narcotics matters, was quick to point out, however, that stockpiles are critically low.

From 1977 on, codeine supply should easily match demand, predicted Dr. William Barclay, symposium chairman. (Codeine accounts for more than 95% of the opium derivatives in the U.S.)

For the remainder of 1975 and 1976, the prospects remain somewhat uncertain, but there is little likelihood codeine prescriptions will go unfilled, Dr. Barclay said. Dr. Barclay is deputy executive vice president of the AMA.

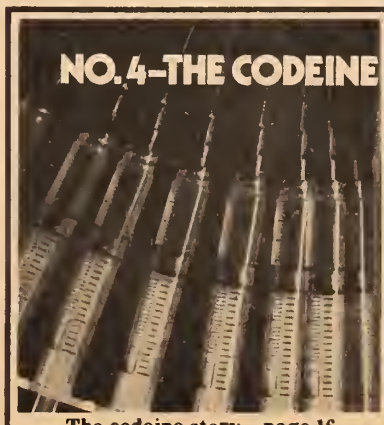
The shift in attitude reflects, in part, the government's reluctance to "oversolve" the problem.

Dr. Robert DuPont, director of the Special Action Office for Drug Abuse Prevention, explained that emphasizing a "shortage" encourages countries to volunteer to cultivate opium poppies for export. Because these countries offer no assurance of controls, the crops could too easily be diverted to the illicit market.

As for the government's softened view of Turkish poppy cultivation, it has been influenced by several factors. One is the obvious need for materials with which to replenish ebbing stocks.

A second is the Turks' willingness to use only the poppy straw method of harvesting. Rather than

(See—Codeine—page 4)



The codeine story—page 16

... INSIDE

BC Police Commission chairman

Prohibiting drugs: 'Sometimes a cop-out'

By PETER THOMPSON

VANCOUVER—Society is paying a price for the policy it is adopting for drug abuse, says Dr. John Hogarth, chairman of the British Columbia Police Commission.

"Law enforcement is no answer to drugs," Dr. Hogarth said. "That's the official position of the commission and of people like assistant RCMP commissioner Gordon Cunningham.

Dr. Hogarth said both he and Cunningham are willing to state publicly that people who use drugs should not be subject to the criminal process.

But, in the absence of alternative enforcement strategies, the police are obliged to carry out their duty and will do it, he said.

"The social policy of the country has been to prohibit certain drug use by law. That sometimes is a cop-out because society as a whole then doesn't have to deal with drugs. They think they can deal with the problem by prohibiting it," he said.

Dr. Hogarth said drug dependency depends up on two factors—knowledge and availability.

"By knowledge I don't mean knowledge of the pharmacological effects of a drug but all the cultural values associated with being a drug user. Availability is impingent on access and price.

"Law enforcement can do very little about knowledge and something about availability," Dr. Hogarth said.

Some of the methods used to limit availability have incurred high social costs, he said. One of the costs of limiting availability of cocaine and heroin is brutalization of the police force. The very nature of such police activity requires violence to property and person.

"That's a public mandate given to the police and I'm not criticizing the police for using it," Dr. Hogarth said.

"The public is asking the police, by the very legislation, to bust down doors, choke people and hit them in the stomach to get them to cough up drugs they have swallowed to avoid detection."

He said that in undercover operations, society is asking a young constable to play criminal for six or eight months.

"There's a real difficulty in socializing that person back to an ordinary role and we've lost a high number of our undercover people because they could not sustain a career in policing. They are lost to the force for reasons which should raise the question as to whether they will ever overcome that kind of experience.

"These are very high prices we're paying."

Although there has been an increase in the number of people dependent exclusively upon heroin in B.C., he said, the rate of increase hasn't been as dramatic as the increase in the number of drug dependents who use a variety of drugs.

"The problem that creates for us in law enforcement is that it is no longer possible to isolate a particular population and develop a strategy for it around the exclusive use of heroin.

"Part of the reason for this is that we (society) have dealt with cannabis the same way we deal with heroin. It's dealt with in the same Act and we have roughly the same enforcement procedures for it.

"What that has done," Dr. Hogarth said, "is integrate the market. Both the suppliers, from the importers down, and the users are drug integrated. We have both an integrated distribution system of hard and soft drugs and an integrated user population."

The crime rate in B.C. is projected to double within eight years, he said. Much of that crime will be related to drugs. (B.C. has more than half of all heroin addicts in Canada.)

The commission's role is to try to make lies of the projections, he said, and the commission is trying to develop approaches which would de-emphasize law enforcement and concentrate on crime prevention.

"We're working on the theory that it is better to build fences at the top of the cliff than to send ambulances to the bottom, but that isn't traditional thinking in law enforcement which has been reactive, waiting for a crime to occur and then reacting to it, he said.

Dr. Hogarth

The trend to de-emphasize street enforcement of marijuana is well-established in B.C., and the spectacular success of CLEU, the Co-ordinated Law Enforcement Unit "will allow us now to rethink the whole strategy of law enforcement in terms of the advisability of street enforcement of heroin," he said.

CLEU is a combined forces unit based in Vancouver and aimed at organized crime, including drug trafficking. Dr. Hogarth said a nucleus of CLEU had existed before in the province but was expanded and given the "proper" resources only last year.

A few months after its formation, it carried out a series of dramatic arrests, seizing more heroin in four months than had been picked up in the last 10 years.

A policy board which includes the deputy attorney general of the province selects targets for CLEU, a research and analysis division provides information, and the investigation section simply zeroes in on the targets, without any other duties or distractions, until they are arrested.

Most of the heroin seized was destined for the U.S., Dr. Hogarth said. The arrests had little effect on the local heroin market but have destroyed Vancouver's reputation as a soft port of entry for heroin for North America.

"What's impressive about CLEU," Dr. Hogarth said, "is that it didn't have to buy an ounce of drugs with taxpayers money. We didn't have to bust down a door, choke anybody or enter into deals with informants.

"The CLEU operations are proving you can have as big an impact without undercover buys with public money. You can spend enormous sums—$200,000 isn't unusual now on what an undercover agent would spend in buying drugs which later get burnt."

He said undercover activities only result in picking up street traffickers, "which makes no dent on the market and gives the public a false sense of assurance that something is being done".

CLEU operations were successful "without brutalizing anyone, including the police (undercover) constable who runs the risk of being brutalized and corrupted himself."

CLEU, he said, will now concentrate on cutting off supplies to the local market of heroin and cocaine. This will have an effect on the local price, and make it more difficult for someone to become a heroin addict.

"But it won't do much for the person who is already an addict. They'll only steal more. There's a price to be paid for driving up heroin prices locally. An increase in crime, prostitution, shoplifting and so on."

Dr. Hogarth readily admits that restricting availability isn't the answer in the long run. The best law enforcement can hope for is to "keep the lid on", not even to stop the problem from growing, but to stop it from growing as fast as it would without law enforcement, he said.

Perhaps the safest thing to say is that all that can be successfully achieved is to cut down the availability of drugs, while realizing that law enforcement has its limitations; provide more sophisticated drug education programs, given that drug education programs until now have advertised drugs rather than deterred people from using them; and expand treatment programs, which have also had limited success, he said.

"Our best social strategy is to limit availability and increase the number of treatment programs. We are going to have to try five or six modalities of treatment, perhaps including heroin maintenance for a small group in an experimental format," Dr. Hogarth said.

"Though we (know of) primary methadone addiction, one of the reasons we have methadone maintenance is that it doesn't have the same stigma that heroin has.

"And maybe because addicts don't like methadone as much as heroin, we feel within us a little vestige of punitive response. We don't want them to like the treatment they're getting.

"Medical people don't like their patients to enjoy their illness. So it's a hang-up most of us have in opposing heroin maintenance in favor of methadone."

Whether methadone or heroin maintenance should be used "is essentially a mythological as opposed to a biochemical or physiological issue", he said.

Compulsory treatment behind Iron Curtain

By JOHN DORNBERG

MUNICH—Hungary, which faces one of the fastest rising alcoholism rates in Eastern Europe, has enacted a law prescribing compulsory treatment of alcoholics.

The law, which took effect at the beginning of this year, stipulates that chronic alcoholics who unreat to the upbringing of their children and to their environment, or who disturb public order and disrupt production" can be compelled to undergo therapeutic treatment in institutions.

They must be committed by county, municipal or district courts on the initiative of the public prosecutor or at the demand of the local public health authorities.

In practice virtually anyone can start proceedings against any alcoholic by turning to the prosecutor's office and requesting it.

Although the period of compulsory treatment is limited to two years, it can be repeated several times if the alcoholic shows no improvement. To terminate it earlier than 24 months, a court decision based on medical reports will be required.

According to the law, an alcoholic ordered to undergo treatment is obliged to submit himself to medical care and to perform whatever work is assigned him.

According to official Hungarian press reports, the number of known alcoholics in the country has increased by more than 20% during the past five years and now stands at 123,000 out of a total population of 10 million.

The treatment to be provided by the therapeutic institutions, according to Jeno Basco, a department head in the ministry of justice, will be administered under medical supervision and will vary according to the character, personality and condition of the patient.

The work to be performed by patients will be remunerated according to a special wage scale.

If the patient complies with the regulations of the institution, no restrictions will be imposed on the use of leisure time, correspondence with family and friends or visiting privileges.

If the patient adopts a hostile attitude or one that "endangers the outcome of treatment or that of others in the institution," these rights and privileges can be curtailed.

Because of budgetary and fiscal difficulties, the establishment of institutions especially for the cure of alcoholics will take some time, Hungarian authorities admitted. At present there is only one such institution in operation.

Located near Szeged, it can accommodate 1,000 patients, although its capacity is expected [illegible] by the end of 1975.

Its patients work in agriculture as part of their therapy and, in addition to the medical, pedagogical and nursing personnel, special guards look after them.

The new compulsory treatment law is part of a pattern of stricter and more severe measures for dealing with alcoholism which have been enacted in recent years.

Under amendments to the Hungarian penal code, for example, intoxication is no longer regarded as a mitigating factor in criminal offences.

Until 1972, a delinquent could be forced to undergo "detoxication" only if there was some connection between his criminal act and his alcohol consumption. A health law passed in that year empowered local health departments to order alcoholics to hospital treatment, but only for periods of up to six months.

Care for addicted mothers

NEW YORK—A comprehensive health care program for pregnant addicts and addicted mothers has been set up at New York Medical College.

It is the first of its kind in this city and federal funding authorities expect it to serve as a model for similar programs nationally.

Called PAAM (Pregnant Addicts—Addicted Mothers), the program will provide a full range of medical, psychiatric, and counselling services.

"The target population of PAAM combines problems that usually exist apart from each other—drug addiction; pregnancy and parenthood; and a very young 'at risk' population, the infants," according to Dr Richard E Brotman, executive officer of the centre.

"Individually, each of these problems is serious. When you put them all together, the situation is exceedingly grave and demands a range of highly specialized services not available elsewhere.

"The infants must be detoxified; they must face the risks of being born into the addict world; and the mothers must be trained to care for them," he said.

In little more than 10 years, the number of pregnant addicts and addicted mothers has increased six-fold in the area served by the college and affiliated Metropolitan Hospital (one of every 29 births at Metropolitan now is to an addicted mother).

The program will operate under a $500,000 federal grant administered by the city's Addiction Services Agency, plus about $262,000 from other sources.

"Besides providing immediate medical care, the thrust of PAAM will be prevention," said Dr Brotman.

"The program will attempt to provide counselling and role models for the mothers so the deadly circle of addiction, complications of pregnancy, and inadequate parental care leading to a new generation of addicted mothers and babies, can be broken."

The first step, he said, will be to "treat the mothers as mothers, not addicts. Thus, they will not be artificially separated from other new mothers in the centre.

"Also, the professional staff will work in 'care delivery teams' composed of an internist, a pediatrician, an obstetrician, a gynecologist, a psychologist, and a nurse mid-wife."

Chemical difference discovered in alcoholics

A MAJOR chemical difference between alcoholics and other people has been discovered that may explain how chronic drinking damages body organs and perhaps why some people become addicted to alcohol.

The discovery was made by a team of physicians at New York's Bronx Veterans Administration Hospital, working under the guidance of Dr Charles Lieber, chief of the section on liver disease and nutrition.

They found that the powerful chemical, acetaldehyde, reaches higher levels in alcoholics than in other people even when both groups have the same blood alcohol level.

Acetaldehyde, a breakdown product of alcohol, is known to be toxic to heart muscle and liver cells. It has also been shown to interact with nervous system hormones to produce drugs called alkaloids which interfere with nerve functions.

Alcoholics often develop cirrhosis of the liver, diseases of the heart muscle, and brain damage.

Thus, the finding indicates alcohol itself may not be the culprit in alcoholism but rather that acetaldehyde may be responsible for alcohol's effects.

If further studies bear this out, they may lead to ways of preventing alcohol-induced damage and perhaps of identifying alcoholism-prone individuals and preventing the disease itself.

The results were published in The New England Journal of Medicine (Feb. 20).

The work is expected to stimulate considerable research. For instance, it is not yet known whether the higher levels of acetaldehyde in alcoholics precede the addiction or are a result of it.

In the Bronx studies, alcohol was given intravenously, allowing precise control over the amount of alcohol in the blood. Simultaneously, measurements were made of alcohol and acetaldehyde levels for eight to 10 hours thereafter.

They showed that the acetaldehyde levels in the blood of the alcoholics reached a plateau that was 62% higher than the plateau of the non-alcoholics.

Acetaldehyde is the substance responsible for the effectiveness of Antabuse in treating alcoholism.

Antabuse blocks the breakdown of acetaldehyde and, when a person taking the drug drinks alcohol, there is a sudden, dramatic increase in acetaldehyde in his blood, far beyond the normal plateau this chemical reaches.

This causes an extreme reaction including nausea, a drop in blood pressure, sweating, and flushing.

Cannabis use not encouraged by Senate witnesses

(Continued from Page 1)

a hazardous substance."

Dr. Bryant, for his part, agreed that there are many recently reported findings that deserve further study, but he saw "no new startling findings about marijuana which dictate immediate changes in policy (of decriminalization)."

"We have sought to avoid our responsibility to suggest reasonable and rational approaches to the use of marijuana, waiting for positive proof of health hazard to bolster society's preconceived notions. I believe this is unwise."

"We possess biomedical proof that alcohol—the misuse and abuse of it—can injure the human liver, the brain, the kidney, the body's resistance to disease. But we do not jail those who simply use alcohol. We do not confuse potential health hazard with criminality. We attempt to educate people as to potential risks.

"I am quite dubious and skeptical about several of the more sensationalized reports of harm—the chromosome-genetic damage, the brain damage, the male hormone malfunctions, etc. Many of them are classic examples of strong opinions attempting to evoke certainty where none exists."

In urging "more rational policies and laws" Dr. Bryant noted that since release of the U.S. National Marijuana Commission reports, all 50 states and the District of Columbia have already reduced first offense marijuana possession from a felony to a misdemeanor, and the state of Oregon has abolished criminal penalties for possession of one ounce of marijuana or less, instituting a system of civil fines.

A survey of the Oregon experience, commissioned by the Drug Abuse Council has shown that since criminal penalties have been abolished for simple possession of cannabis, only one half of one per cent of those currently using the drug, were induced to do so since change in the law.

On the other hand, 53% of those who have used marijuana but are no longer using, cited lack of interest, and 23% possible health dangers as their motivations for stopping. Only 4% cited fear of the law as their justification for moving away from marijuana.

A similar study in California, a state with some of the harshest penalties in the nation for both sale and possession of marijuana, showed that only 8% of those surveyed have refused marijuana for fear of legal consequences, whereas 38% cite possible health dangers as their reasons for not now using the drug.

"Fears that marijuana usage would dramatically increase if criminal penalties were removed are not borne out by our survey," emphasizes Dr. Bryant.

"(This seems) to indicate that the use of punitive criminal sanctions to control marijuana usage is in fact not effective," he said.

In other testimony, Dr. Patrick L. McGeer, member of parliament from British Columbia, and Richard M. Anthony, Chairman of the Alberta Alcoholism and Drug Abuse Commission recommended mandatory educational programs for cannabis law offenders.

Dr. McGeer urged that for first conviction on charge of simple possession (one ounce or less), the sentence include a fine coupled with a compulsory drug education course "not a course which soft peddles the dangers of cannabis but one which tells the whole story."

For subsequent possession offences, Dr. McGeer recommends registration of the individual's name and compulsory treatment by medical and social authorities, and the option of imprisonment with parole available through community service programs.

Dr. McGeer also recommends that possession of more than one ounce of marijuana, and offences for cultivation, importation, and trafficking be assigned mandatory jail sentences.

Mr. Anthony, of Alberta, urges a much tougher line—legal provisions to provide programs in which individuals accused of offences would be allowed to participate in return for absolute discharge.

These pre-trial programs would be aimed specifically at first and second offenders.

Anthony also suggested that cannabis remain under the criminal code, not the civil code which he said appears so difficult to enforce.

"The new legislation is tending to treat the first offenders for possession of marijuana or hashish in the same manner as if the person committed a minor traffic violation or as found guilty of allowing his dog at large without a leash."

The Senate should not consider decriminalization for possession, said Mr. Anthony, until the existeffectively guarantee the prevention of repeated use among young offenders.

TV cameras in action at Senate cannabis hearings

Cigarette tax increase urged by U.K. doctors

By THOMAS LAND

LONDON—Five eminent British doctors, four of them Presidents of Royal Colleges of Medicine, have called for a substantial increase in the tax on cigarettes in order to raise revenue to aid the ailing National Health Service (NHS).

Their statement coincides with a new national campaign warning women of the dangers of smoking during pregnancy, launched by the Government-backed Health Education Council.

"Past experience has shown," the doctors argue, "that a 10% increase in taxation results in a 6% decrease in tobacco consumption. It is worth noting that, in terms of purchasing power, cigarettes are at present cheaper than 10 years ago. Moreover, it is surely absurd that expenditure on this dangerous and damaging habit is included in the cost of living index."

Smoking and Health Now the latest report on smoking prepared by the Royal College of Physicians in London, notes that early death and crippling sickness caused by cigarette smoking have reached epidemic proportions, presenting the most challenging of all opportunities for preventative medicine in this country.

The statment by the five doctors has been made in the context of a heated national debate over the inadequate financing of the free NHS medicare system.

They stress: "No government can convince us, as doctors with responsibility for the health of the nation, that they cannot afford adequate resources for the Health Service when they have failed to take an action which will not only help to provide those resources but also help to save many thousands of people from misery and death. Furthermore, the cost in foreign exchange of importing tobacco was £153.8 million (about $354,000) in 1973 and is estimated to be £166.5 million ($383,000) in 1974 . . .

"There is, to us, an unanswerable case for tax which can not only help to provide resources for the Health Service but save greatly needed foreign exchange and substantially benefit the health of the nation."

Smoking caused at least 24,000 deaths in Britain from lung cancer during 1972, 14,000 deaths from chronic bronchitis, and 16,000 deaths from coronary artery diseases in people under 75 years of age. It also contributes, the doctors explain, to cancer of the mouth, gullet, larynx, bladder and pancreas, in smaller numbers, and is an important factor in illnesses due to peptic ulcer and tuberculosis. It gives rise to an immense amount of invalidism and misery from chronic bronchitis, the biggest single medical cause of loss of work in Britain, resulting in the loss of more than 30 million workdays annually.

Toronto lawyers favor . . .

'No minimum penalties'

OTTAWA—A group of Toronto defense lawyers told the Senate Committee on Legal and Constitutional Affairs that they would have preferred to see the proposed cannabis legislation eliminate minimum penalties altogether.

"With the exception of non-capital or capital murder, and with second or subsequent offences for impaired driving, there are no minimum penalties provided in the Criminal Code of Canada," the lawyers brief said.

"We do not think they are warranted in the narcotic or drug-related statutes."

The lawyers argued that "the court ought not be hampered by minimum statutory requirements provided it has sufficient discretion and lattitude to impose whatever sentence it deems proper."

They also recommended that where an accused under the cannabis bill could go to jail for up to 18 months—such as under summary conviction for possession for purposes of trafficking—he ought to have the right to a trial by judge and jury and all the safeguards that such a trial provides.

"We make this submission particularly because of the peculiar procedure provided for in the statute for charges involving possession for the purpose of trafficking, wherein the onus is on the accused to 'establish' that he was not in possession for the purpose of trafficking.

"The precise nature of the accused's onus could be debated, but the fact that such an onus exists is clear. In such cases, it is almost always necessary for an accused to testify, thereby forfeiting his 'right' to remain silent.

The lawyers argued that the accused should have the benefit of a preliminary hearing, full disclosure by the Crown of the nature of allegations against him, and trial by jury.

Stopping smoking? Anything goes

By DAVID EHRLICH

GENEVA—Is it easier to quit smoking abruptly or to use tricks simply to reduce the habit and hence the danger?

A leading fighter favors all sorts of psychic devices.

"Puff, don't inhale," says Dr. Daniel Horn, medical psychologist and biostatistician, and director of the United States National Clearing House on Smoking and Health.

"I know a fellow who takes quick puffs and alternates with deep breaths of air!"

Dr. Horn was here at the World Health Organization for an international conference to exchange medical evidence, control methods and their effectiveness. "How to quit" was a main question.

A principal contributor to the historic Surgeon General's Report which lined smoking and lung cancer and changed smoking history, Dr. Horn continues research today, exploring every conceivable method of "cutting down".

When a skeptic snorted at the story of "quick puffs" and breathing, Horn said: "Don't knock it. Tricks are welcome if they affect deep-seated habits. *Any change* that decreases dependence is good. It is then easier to quit. A series of unconscious actions goes on. We don't yet understand it.

"Medical remedies or pills are no solution to this dependence," says the psychologist. "People use cigarettes for different purposes, as with most drugs. But it's especially true of cigarettes because they have very modest physiological effects.

"Women have a much more difficult time quitting, we find, because more of them use cigarettes as a tranquillizer, to reduce negative affect and tension. Men use them mostly for positive reasons, for pleasure.

"It is easy to give them up when things go well, if you've been using them to relieve tension. But even minor crises in daily life strongly tempt you to resume smoking. That's the problem of most women smokers. . . .

"There's no overall solution. It's a matter of figuring out yourself how smoking fits into your life-style and trying to find other gratifying, less noxious habits."

The international group, evaluating other control methods, found high taxes and price beneficial, simultaneously decreasing consumption of many smokers and raising increasing revenues for social services. Some would like to threaten high insurance premiums for smokers.

Despite State tobacco monopolies in some European countries, several, especially in Scandinavia, are passing stricter laws to prohibit promotion and are waging intensive educational campaigns, using sports and other celebrities to convince the young.

The group also recommended more restricted public places, "upholding the rights of non-smokers to breathe non-polluted air", as Dr. Raoul Senault of Paris, president of the new and active International Union of Health Education, said.

"A few years ago, non-smokers were a timid lot," he observed. "They wouldn't risk offending the swashbuckling majority of smokers. Today they are bold and smokers are at last on the defensive. In an institute's or laboratory's dining room or cafeteria, you see almost everyone enjoying a meal without pollution. The non-smoking section of airplanes is now usually over-subscribed."

(Airplanes have the best air conditioning, studies show, with 16 complete exchanges of air per hour. The average office building has only 6 and the home ¾ of 1 exchange per hour.)

About 25% of all victims of fatal heart attacks are smokers and up to 75% of those, men under 50, cardiologists of the UN health agency estimated. Cigarettes are also associated with chronic bronchitis and emphysema, they added. But the lung cancer risk for those who have quit for 5 years falls toward that of non-smokers.

In Britain, the risk rate for doctors has dropped in the past 10 years, despite the increase in their age, because so many have quit, according to Sir George Godber, recently retired Chief Medical Officer of England and Wales and chairman of the WHO conference.

"Many smokers argue that nothing happens to some smokers," Dr. Horn says. But smoking does hurt. Whatever is wrong with you, smoking will make it worse. It increases the disability of chest diseases, demonstrably slows healing time of stomach ulcers and reduces athletic performance.

"The question isn't only whether smoking *causes* certain conditions. It exacerbates any predisposition to disease, such as diabetes, obesity, hypertension, high cholesterol levels—and *most people* have some such predispositions."

Smoking produces much more dangerous amounts of carbon monoxide in a room that automobiles do in a city, Horn says. He carries a measuring instrument and when it registers 25 ppm he leaves the conference room.

Smokers on the Los Angeles freeways were tested. They arrived at work with CO indices of 6 to 8, compared with non-smoking drivers' 1.5 to 2, and natural levels of .8 to 1.

"The amount of carbon monoxide ingested by smoking—the more personal pollution—is much greater than that from air pollution," Horn says. When corrected for smoking, the statistics on lung cancer show little difference between town and country, he adds.

German women keep well-stocked bars

BERLIN—Alcoholism has been rising among German women for the past 15 years, according to Dr. Lothar Schmidt of the Judisches Krankenhaus here.

In 1960, only one woman in 25 treated by this city's sociopsychiatric service was alcoholic. Today the rate is one in seven.

An estimated 15% of such patients in the Federal Republic are women. Of these, 45% are housewives, 35% are in high income brackets, 2% are university graduates and 1% are pensioners, researchers suggest.

Affluence contributes importantly, Dr. Schmidt believes, for women can now "keep house bars well stocked". But he suspects women also drink to "escape" when confronted with problems that seem beyond their abilities.

Psychologists have discovered 90% of such patients in sanatoria have marked infantile attitudes and lack self-confidence. Two thirds cannot easily establish contacts and about 80% have had marital or earlier family trauma.

The war, it has been suggested, was particularly traumatic for women now between 35 and 45 years old. Many faced starvation and had to look after themselves. Today, many apparently cannot cope with the demands of the vastly changed society.

French get tough on smoking habits

PARIS—With the aid of public funds recently authorized by several government agencies, the French National Anti-Tobacco Committee is planning a greatly expanded program in 1975, Mr. de Givry, its director, said in an interview here.

Among actions planned are a public information program using the media, a special information program aimed at young persons, and an attempt to reduce the facility with which young persons, particularly those in military service, obtain their tobacco.

In addition, the committee will attempt to limit publicity in favor of tobacco, require cigarette manufacturers to put a health warning on every packet of cigarettes, aid smokers wishing to quit smoking, and find ways for non-smokers to avoid smoke in public places.

According to the committee, the French consume three billion packets of cigarettes each year, with young people smoking more and at lower and lower ages (half of all lycee students smoke at age 15), and an increase in women smokers.

Although the French government has an interest in cigarette smoking, since it receives 5 billion francs each year from the sale of cigarettes, Mr. de Givry, a former director of the National anti-alcoholism committee, did not feel that the anti-tobacco forces would encounter resistance of the order encountered by anti-alcoholism forces.

"The number of people making their living by the production and sale of tobacco in France is much less than the number living off the sales of wine," he said.

Comité National Contre le Tabagisme, 12 rue Jacob, 75006 Paris.

TC's JOIN FORCES

DESPITE A tradition of relative isolation, not only from society at large but from each other, therapeutic communities may in future present a more united front.

At a recent meeting in Winnebago, Wisconsin, representatives of TCs across the continent formed the North American Association of Therapeutic Communities.

The organization is designed to further the purposes of the movement by establishing lines of communication among existing therapeutic communities.

According to Michael Sack, director of the Tellurian Community of Winnebago, and chairperson of the association: "The NAATC sees itself as a forum from which the communities may address the public at large, and an arena within which the communities may address each other and exchange information vital to the growth of the movement."

While there are no figures available as to the exact number of such communities in North America, the NAATC has identified more than 350 with a total population estimated at between 8,000 and 12,000 people.

Codeine: 'No need to push panic button'

(Continued from page 1)

lancing poppy capsules to obtain opium in gum form, poppies are harvested intact, somewhat like wheat. Because the straw is difficult to process, and bulky to conceal, chances of its being diverted to illegal use would seem greatly diminished, Dr. DuPont said.

Yet another factor to influence the government's stance, according to Ambassador Vance, is the decline in U.S. heroin traffic from its all-time peak in 1971.

"When the Turkish decision to ban the opium poppy production was announced, we predicted that the European heroin traffic would be diminished," the ambassador said.

"The decline in the number of heroin dependent persons that followed gives us some reason to think that our policy was correct."

In any event, the Turkish ban in late 1972 was not the cause of the current codeine "shortfall", Ambassador Vance declared. Turkey has never supplied more than 10% to 15% of the world's legitimate market, he said. Rather, diminished opium supplies are the result of a combination of situations in different parts of the world.

For one thing, drought sharply reduced India's production of opium: In the three years 1973, 1974 and 1975, India fell short of expectations by 600 tons.

In that same period, the USSR was switching from being an exporter to an importer of codeine. Although Russia never explained why, its production of opium dropped from 227 tons in 1970 to 93 tons in 1973.

Simultaneously, the demand for codeine was rising dramatically in the U.S. Between 1967 and 1973 bulk codeine sales shot up 73%.

In the industry's view, rising demands corresponded with a 50% increase in the number of patients covered by private health insurance which pays for prescribed drugs.

Authorities estimate the U.S. will need between 37,000 and 41,000 kg of codeine in 1975.

There is enough material available—in manufacturers' pipelines, from the stockpile release, from confiscated illicit supplies, and from the Indian market—to cover these needs, Donald Miller told the symposium.

"There's no need to push the panic button," said Mr. Miller, chief counsel to the Drug Enforcement Administration.

Exhausting all these resources, however, would both drain manufacturers dry, and leave no margin of safety.

Consequently, U.S. manufacturers are expected to bid on the open market for enough straw concentrate to produce an additional 6,000 to 7,000 kg of codeine.

Iran and Poland, as well as Turkey, are potential sources of poppy straw, Mr. Miller reported.

The Turkish crop this spring will be larger (16,000 tons) and higher in morphine content (because the capsules have not been lanced) than ever before.

Whether the U.S. should grow its own poppy supply (Papaver bracteatum) is being debated by the Opium Task Force, its chairman, Dr. Edward Johnson, declared. The Task Force is trying to achieve consensus by July, so a crop could be planted in the fall, if the plan gets the go-ahead.

Government and industry laboratories, as well as the UN, are trying to determine the abusability of the bracteatum's thebaine.

Thebaine derivatives, experts told the symposium, are many times more potent than heroin. There is no history of their having been abused, but no consensus as to why not.

Poppy straw method will preclude problems

THE POPPY straw method of harvesting, supported by a government decree, will prevent any opium leakage from Turkish fields to the illicit market, predicts Sir Harry Greenfield.

The formal decree, announced in January, forbids the lancing of any poppies grown in Turkey.

Sir Harry, retired director of the International Narcotics Control Board, assured the AMA symposium that the Turkish government is planning strict measures to enforce the ruling.

All relevant departments are cooperating, and the government is seeking United Nations advice.

"The Turkish police and gendarmerie are quite respectable, in the best sense of the term," Sir Harry said. Moreover, the Turks are "very forthright in enforcing the law".

Twenty thousand hectares have been planted with Papaver somniferum, and every field is carefully charted on a map, Sir Harry reported. Each cultivator is licensed. The area he is allowed to cultivate is strictly limited and described in detail on the licence.

At harvest time, police will increase their efforts, taking on special staff to handle the extra surveillance. They may even use helicopters to patrol the fields.

The poppy straw method of harvesting will also make diversion difficult. The lancing of poppies yields an opium gum: The gum is compact and a ready source of heroin. Poppy straw, on the other hand, is both bulky and difficult to process.

"With only unincised poppy capsules available, there should be no opium at all in Turkey, except what might have been hidden under the bed from the '72 crop," Sir Harry declared. "There might be some seepage, but no leakage."

Private hospital for middleclass alcoholics

Gillain Manor: a dream nears reality

By PETER THOMPSON

VANCOUVER—A private hospital on Vancouver Island for middleclass alcoholics is renegotiating financing and hopes to continue construction so it can open this summer..

Gillain Manor, located 15 miles north of Victoria in the pastoral Saanich Peninsula, was three-quarters completed when monetary policies in North America made mortgage money scarce and brought financial problems to the project, according to J. George Strachan.

Mr. Strachan, president of the development company which is building the hospital, and a well-known figure in Canada's alcoholism fraternity, said financing for the project had been arranged but disappeared when interest rates soared.

The development company has been petitioned into bankruptcy by contractors. But Mr. Strachan is confident that now that interest rates are decreasing, mortgage money will become available. He said he is negotiating new financing and construction of the hospital will resume in time for an opening early this summer.

Once construction is complete, the development company will either lease or sell the hospital and its 100-acre site to Gillain Foundation, a non-profit organization incorporated under the Societies Act of B.C.

So far, about $1 million has been spent on the hospital, and slightly more than $2 million is being sought in mortgage negotiations, he said.

It will be able to treat 50 patients when it opens and plans call for an immediate expansion to between 80- and 100-bed capacity, Mr. Strachan said.

"It represents a dream I've had for seven years now. I've looked all over the west for the right site," he said.

The hospital is on a wooded bluff overlooking the islands and mountains of the B.C. coast. It aims at providing a service to middleclass alcoholics in western Canada and the U.S.

A document on Gillain Manor says experience shows that 95% of alcoholics are in an above average sector of society. While they admit they have a drinking problem, they resist the implications still reflected in the term "alcoholic". They are reticent to go to Alcoholics Anonymous or use public services.

"Anomalous though it may seem, in terms of treatment, these are the underprivileged," the material says.

Gillain should not be confused with "rest homes", which wealthy alcoholics use as a hideaway to recuperate from binges.

"Known as 'drying out' and 'jitter' joints, they serve a temporary use at a price, but offer little towards permanent sobriety.

"Many such facilities," the document says, "serve a regular clientele who are in and out as often as less fortunate inebriates are in and out of jail."

Less than 5% of alcoholics, Mr. Strachan said, are on skid row. Yet it is at this highly visible minority of the alcoholic population that most public programs are directed.

Despite financial difficulties, Gillain Manor is expected to open this summer

"Alcohol dependency ranks highest among the professionals in the fields of medicine, psychiatry, law, religion, education and the arts and sciences—and their spouses.

"This supports the belief," the document says, "that most alcoholics are above average in intelligence."

Mr. Strachan was born in Montreal and educated in Canada and the U.S. He graduated from the Yale (now Rutgers) School of Alcohol Studies in 1950 and helped establish similar facilities at the University of Wisconsin and Marquette University Labor College.

From 1953 to 1965 he was director of the Alcoholism Foundation of Alberta. He was a leader in establishing the Canadian Council on Alcoholism, the forerunner of the Canadian Foundation on Alcohol and Drug Dependencies. Mr. Strachan is a founding member and honorary life member of the foundation.

Pot discharge provisions still misunderstood

By BRYNE CARRUTHERS

OTTAWA—The federal government is growing increasingly concerned about the general lack of knowledge among persons accused of simple cannabis possession with respect to the availability of special discharges, in place of convictions.

And the National Parole Board is also investigating why those persons given absolute or conditional discharges, instead of formal convictions, must apply to the board to get a pardon.

Under the special discharge provisions, a person is considered guilty by the court but is not formally convicted. Instead, the person is given a discharge, either absolute (without any conditions) or conditional (with some sort of probation attached).

But despite the fact that there is no conviction, under the present law the persons given the discharges for simple cannabis possession offences are still given criminal records.

And even though eligibility for applying for a pardon, to have the criminal record erased, is shorter with a discharge than with a formal conviction, there is still the hassle of applying and then being investigated to see whether a pardon is appropriate.

There have been some suggestions that the pardons should be given automatically, though the government has so far refused to grant such requests.

The National Parole Board is itself studying the legal reasons why there is a criminal record in the first place associated with the discharges.

If it turns out that there really is no legal need for a criminal record, then the question and the hassle associated with getting a pardon could be automatically eliminated.

While that would be good news to some, there still is the broader issue of why so few discharges are being granted in the first place.

The parole board seems to think it may just be a problem of the lack of knowledge of the availability of the provisions.

But investigations by **The Journal** have suggested that most lawyers involved in drug cases just don't ask for the discharges, despite the fact they are aware of them. Often, they think the judge won't grant them anyway.

Finally, for those persons already convicted or given discharges for drug crimes, there is some other promising news relating to pardons.

As part of an as yet not fully detailed broader reform of pardons and paroles being contemplated by Ottawa, the government is considering simplifying the pardon application and granting procedures.

In certain instances, the board might be able to grant pardons without requiring the lengthy and complicated police investigations now required. Generally, the board hopes to be able to reduce the investigation time where it is still needed.

And the government is also considering relating the waiting period before pardon eligibility to the length and kind of sentence.

Thus, the eligibility time would generally be shorter than the existing periods: two years for summary convictions and five years for indictable offences.

Clinical model applied

Drug workers' skills enhanced

NEW YORK — The attempt is being made, in a novel project in the Bronx, to bring professional mental health skills to ex-addicts and other drug treatment program counsellors. The aim is to upgrade clinical care in drug-free programs.

The consultation and training project, based at the Montefiore Hospital Department of Social Medicine, is led by psychologist Dr. Robert Cutler, and includes three other psychologists and a social worker who spend most of their professional time each week visiting the dozen treatment programs whose staff members they are counselling on therapeutic techniques.

"The focus is on maintaining ethical and appropriate treatment services," Dr. Cutler said in an interview. "Confrontation and TC approaches sometimes don't suffice, especially when many of the clients are appearing with severe psychiatric problems."

The dozen programs to which the consultation service is offered, including Argus Community, Logos II, Inward, and Resurrection, serve more than a thousand clients in the Bronx. Some of the programs provide day care. Others are aimed at prevention, and still others are traditional residential TC's.

Dr. Cutler said he and his professional colleagues worked during their project's first year to assess, with program staffs, the particular client populations and staff training needs of each program. They listened in on therapeutic activities in the programs, but did not actively participate in therapy or assume supervisory responsibility. Then, in staff meetings and counselling sessions they worked to build staff members' levels of basic therapeutic skills, including diagnosis and appropriate treatment referral.

In the project's second year, now underway, Dr. Cutler said emphasis is being placed on enhancing drug workers' skills in special types of therapy, such as group and the treatment of adolescent clients.

"What we're doing is applying a clinical training model to paraprofessional counsellors, including ex-addicts," he said.

The training project is funded with a $26,000 federal grant from SAODAP. Dr. Cutler hopes to find other grant funds when the federal money runs out later this year.

He said the project at first met "rather a great degree of suspicion," in part due to the historical conflict between professionals and paraprofessionals that it was intended to abate. In addition, there were "the endemic kind of fears the programs have toward professionals," and "toward their concern" that "we may be spies for funding sources."

In fact, Dr. Cutler says, the New York City Addiction Services Administration asked that he and his staff evaluate the programs to which they provided consultation. He refused, he said, emphatically.

Having spent more than a year in assisting paraprofessional treatment personnel, Dr. Cutler said that he finds their major weaknesses to be record keeping, the capacity to make differential diagnoses, and the ability to structure programs to meet their particular client's needs.

Their major strength, he said, is that "they came from the same kinds of community as the clients they work with, and so have a great deal of empathy—an intuitive awareness—of some of the problems and difficulties with which their clients must contend."

"That," he added, "is what we're building on."

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Health care system sadly deficient

COMPARED TO the heroin addict, the non-opiate abuser is in a sadly deprived state when it comes to adequate treatment.

Some authorities involved in the scene claim that technology in the non-narcotic area is at the stage heroin treatment was 10 years ago—before methadone and before the therapeutic community.

This is so despite the fact that there are many more non-opiate (non-alcohol) abusers than there ever were heroin abusers. The National Institute on Drug Abuse estimates there are at least two million such "walking wounded" in the United States, only a fraction of whom ever see treatment.

The growth of non-narcotic drug abuse presents the health care system with an immense challenge.

First there are the many young users, supplied by street sources, who really have very little idea about the drugs they are taking.

A recent Addiction Research Foundation of Ontario study showed that less than half the street drugs consumed by these unwitting buyers are what the dealers say they are.

The great street rip-off is nothing new. Analysts have been emphasizing the street drug fraud for years, but it apparently hasn't deterred the users from shelling out a lot of money for what they think may be mescaline, or cocaine, or whatever.

Another complicating factor is that most drug users don't confine themselves to one drug, or even to one class of drugs.

A recent study by Drs Harold and Oriana Kalant (See **The Journal**, March 1975) showed that among 26 amphetamine-related deaths in Ontario, 18 involved the presence of other drugs: MDA, alcohol, methaqualone, barbiturates, minor tranquilizers.

Last year, of 1,200 people admitted to a series of polydrug pilot research programs in the United States, 97% reported abusing more than one class of drugs simultaneously.

Certainly, this mixing and matching does nothing to help the attending physician, already forced into some kind of clinical roulette, in determining how to treat the drug victim.

But the low status of the art is not attributable solely to the fact that drug users don't want to play by someone else's rules. The fact is that the health system itself has been sadly deficient not only in dealing with those drug abusers who have volunteered for treatment, but by perpetuating a situation whereby drugs are used inappropriately.

Anti-depressants and minor tranquilizers, for example, are primarily described for mental disorders. Yet psychiatrists and neurologists account for only one third of the prescriptions for these drugs.

The great majority of psychotherapeutic drugs are prescribed by general physicians and internists. One recent study showed that 85% of respondents who used prescription psychotherapeutic drugs had never seen a psychiatrist professionally in their lives.

In addition, there is increasing evidence that those non-opiate, polydrug users who are turning up for treatment are sick individuals indeed and in many cases have already gone through the conventional health system with psychopathology untreated.

It is disturbing to learn that almost half of the patients admitted to existing polydrug programs have previously undergone multiple psychiatric visits and/or involvement in other drug programs, yet they still have problems with drugs and their psychopathology continues.

The North American health-industrial complex is massive. In size and expenditure it is one of the top half dozen industries on this continent.

Various agencies are now concentrating on developing and licencing specialists in drug treatment. This is fine and it should be encouraged.

But it is also time that some clear, precise guidelines were established to show how the existing health care system can become relevant to these millions of "sick" people.

"How about offering green stamps to cover funeral expenses..."

Letters to the Editor

Sir:

I was interested in the article by Bryne Carruthers in **The Journal** (Feb. 1, 1975) on the new Federal Drug Bill.

However I am somewhat concerned about the statements respecting possession and trafficking which he advises are proposed in the new Act. His article does not inform people that under the present Narcotic Control Act the procedure already exists. I quote Section 8:—

Sect 8:

"Any prosecution for a violation of subsection 4 (2) (no person shall have in his possession any narcotic for the purpose of trafficking) if the accused does not plead guilty the trial shall proceed as if it were a prosecution for an offence under section 3 (no person shall have a

(See—Letters—Page 11)

The goose that laid the golden egg

By Wayne Howell

To: The Executive Director
'New Improved' CFADD
Ottawa, Ontario

Whereas we have received a request that the Royal College of Arms should devise, ordain, and assign to the 'new improved' Canadian Foundation of Alcohol and Drug Dependencies, arms and ensigns armorial symbolic of the new improved CFADD's heritage and stated goals, we do hereby appoint and declare that the Arms or Ensigns Armorial of the new improved CFADD shall be blazoned as hereinafter described:

For Supporters, on the dexter, an oie Or rampant—the golden goose being the symbolic representation of the Non-Medical Use of Drugs Directorate from which issued the Golden Egg of a $125,000 'innovative services grant'.

On the sinister, a dindon Purpure rampant—the purple turkey being the symbolic representation of the old CFADD which managed to meet at Her Majesty's expense for 20 years without ever once doing or saying anything that would justify its existence.

The Shield of the new improved CFADD shall be Tierced in fesse: In the Third Division, upon a field Argent, an oeuf Or proper—the Golden Egg laid by the federal goose.

The First and Second Division shall contain the quarterly coat following, namely:

First Quarter: Upon a field Argent, a hand sinister, couped, apaumé—the open hand symbolizing new improved CFADD's willingness to accept federal monies now and forever after.

Second Quarter: Upon a field Vert, an amorphous blob proper—symbolizing the fuzziness and vagueness of such CFADD objectives as 'working towards a system that would stimulate and encourage a society where people are conscious of the right that they have, through personal decision, to influence the activities and forces of their lives'.

Third Quarter: Upon a field Azure, a scymetar engrailed Argent—the fearsome weapon with which the CFADD plans to 'cut the strings of society's values and expectations that subtly control the consumption of alcohol and other drugs'.

Fourth Quarter: Upon a field Argent, a dexter cubit arm vambraced—the clenched mailed fist symbolizing new improved CFADD's determination to recruit enough members with the money it was given to convince the government goose to lay another golden egg three years hence.

Our Will and Pleasure further is that the Arms or Ensigns Armorial of the New Improved CFADD ought to be used.

The Royal College of Arms
London

MRS MARTY MANN: *'A Messiah figure for tens of thousands'*

"The idea was to change public ideas on alcoholism. I am still talking 35 years later."

MARTY MANN'S life is an amalgam of pages from F. Scott Fitzgerald, Virginia Woolf and a bad Hollywood script.

A gay and rich young girl in the roaring Chicago of the 1920s and an artistic Bohemian moving among the London litterati of the 1930s.

"There is something about this subject that keeps you re-enthused."

A crush into the private hell of acute alcoholism and nearly two years in a psychiatric hospital. Inspired, while working on morale-boosting radio programs during World War II, into a crusade. Then, resurrection as almost a messiah figure for tens of thousands.

Today, though slow of gait, she belies her years in almost every other way. Since founding the National Council on Alcoholism she has never stopped.

Two days a week helping alcoholic patients are mixed with constant public speaking engagements and 60,000 miles of travel a year. Her strong, unwavering, precise diction keeps audiences hushed. With facts, not histrionics, she paint an uncompromising picture of alcoholism and what can be done about it.

When she is finished, well wishers crowd round; more often than not they include former alcoholics she has helped raise from the ashes. There is always a smile and a spark of enthusiasm and encouragement.

It is a world removed from her youth in Chicago where her father was a wealthy man connected with the Marshall Fields department store empire. Life was dates and parties and drinking.

"I was fortunate: I had a father who had laid in a big supply when prohibition came so there was plenty of liquor at home," she points out. And it flowed.

Every dinner engagement meant a few drinks before leaving home in case the host had a short supply. A new date always required a couple of drinks so the ice was broken even before he had time to pull out his hip flask.

Mrs Mann could drink anyone else under the table. "I had an endless capacity. I never showed any signs of it. I never got drunk or had slurred speech or wobbly legs. I took everyone else home and I was proud of it."

The Wall Street Crash of 1929 brought a sudden end to the rich life but not to the drinking. It did mean she had to look for a job for the first time. Eventually, with a small inheritance from an aunt, Mrs Mann pulled up stake and sailed from New York in 1930.

"At that time everyone thought the good life was in Paris. But I decided to try London instead and I stayed there seven years," she says.

Because of her department store background, Mrs Mann knew the ins and outs of glamor photography and advertising and she decided to show the behind-the-times British how to do it. She was so successful that she soon went into partnership with a woman photographer and opened a studio in King's Road, Chelsea.

She moved freely among the writers and artists of the then fashionable Bloomsbury Set. "It wasn't hard to get into and it was easy to meet people," she explains.

Eventually Mrs Mann left her partner and went into business with a young German refugee who had started out as a helper in the studio. But by 1937, the realities of the life she led caught up with her and she returned to New York.

"When I got back I didn't know what I was going to do. I had no job and I had no money but I did have a sister living there so I went to stay with her.

... 'facts not histrionics'

"I had a very bad first year in trying to find a job. I was unable to stay sober. I was not a periodic drinker, I was a constant drinker. My world had fallen apart.

"I kept trying to find a doctor who would tell me what was wrong with me. I realize now that a lot of the denial we talk about comes from the internal fear the alcoholic has that he is really crazy.

"He is so afraid he is going to be locked up he will do anything to deny it even to himself. And I went through that."

Seven psychiatrists consecutively refused to help her. The eighth, Dr Foster Kennedy, a transplanted Irishman who was head of the departments of both neurology and psychiatry at Cornell University, took a chance.

"Father laid in a big supply when prohibition came."

He told Mrs Mann, she recalls: 'You know, in my experience people like you ("that is what I was always called") have one chance in a hundred but you want to get well so badly I am going to take a chance on your being that one.'

The long, and often painful, journey down the road to recovery had begun. It would take nearly two years in hospital and sporadic binges before help from a group of former alcoholics succeeded.

"After that I had three relapses in the first 18 months but never since then. That will be 35 years in April."

She got a job as fashion publicity director of R. H. Macy in New York and when the United States entered the war she went to work for an organization that prepared 10-minute radio scripts for the Office of War Information. They were sent out once a week to 800 radio stations.

Mrs Mann wrote all of the scripts, generally about little known incidents in American history. One of the people she ran across in her research was Dorothea Dix, a young woman who in the early part of the 19th century spent her vacations from teaching, visiting the jails, and sketching the "crazy" inmates.

Miss Dix was so determined to get something done she went to the Massachusetts legislature and spoke for three hours. Finally, she succeeded in seeing America's first mental hospital opened in Worcester.

Mrs. Mann is proud that psychiatrists now often introduce her as "the Dorothea Dix of alcoholism".

Her own crusade began. "I thought that if she could do that for the mentally sick, why couldn't I do that for alcoholics?"

"I sketched out a plan for a national education campaign with the object of getting beds in outpatient clinics. I knew I had to have scientific backing, especially as I was a layman, and a woman, and an ex-alcoholic."

A doctor friend helped her contact officials at Yale, the only place, at the time, where anything was being done about alcoholism.

The Yale scientists were keen so she gathered together a board of directors, got financial backing, and "for five years in what was then called the Yale Plan on Alcoholism I travelled around the country lecturing and trying to organize local groups wherever I could.

"The idea was to change public ideas on alcoholism. I am still talking 35 years later."

Mrs Mann has an apartment in New York and a home in Connecticutt. Two days a week she works with patients at a private psychiatric clinic.

Travel and talk never tire her. "There is something about this subject that keeps you re-enthused. One of the things is to see people recover.... to see them come in a mess and eight weeks later go out looking wonderful.

"You see them a year later in some other part of the country and they are still wonderful. It makes you feel good."

Although she is addressed as Mrs, the Mann is her maiden name. Her marriage in 1927, and divorced in 1928, is perhaps the greatest irony.

"One of the things is to see people recover."

"I married a drunk. I had no patience with him. I had no understanding. I thought this guy was a weak sister, a liar and cheat.... all the attitudes I am trying to change. That's why I know them so well."

Text by Ashley McConnell

Photographs by Ralph Robinson

Retention rates "fairly high"

Alcohol treatment methods compared

By MARY HAGER

ARE SOME TYPES of treatment for alcoholism more effective than others?

Do some alcoholics respond better to one type of treatment than another?

In an attempt to answer such questions, a University of Kentucky research project known as SHARP (Self-Help Alcoholism Research Project) assigned patients to four different types of treatment on a random basis and followed them through treatment with plans for a one-year follow-up study.

Jeffrey M. Brandsma reported that 206 patients were randomly assigned to rational behavior therapy conducted by professionals, rational behavior therapy conducted by a lay person, professional insight therapy, or Alcoholics Anonymous, with a fifth group of 36 used as a control.

He noted that 20% of those assigned to treatment never reported for therapy.

Only 80% of those who did show up for the first session in the AA group returned a second time, compared with 89% for the insight group, 95% for the non-professional ration behavior therapy group and 93% for the professional group.

By the tenth session, attendance in the AA group had dropped to 38%, compared with 62% in insight therapy, 51% in the non-professional rational behavior therapy and 62% in professional rational behavior therapy, he noted, adding that 53% of the total number of patients who had attended the first session had remained in therapy.

This overall retention rate is "fairly high" he observed, considering that patients were required to attend a total of 10 therapy sessions and showed that both rational behavior therapy and insight therapy did have fairly good holding power.

The retention rate of 38% for AA also is good compared to national averages for psychotherapeutic treatment, he continued.

But, he said, the majority of patients in all groups were court referred and had follow-up if they did not attend.

Also, he said, "AA has claimed a high success rate but while there are numerous individual examples of AA successes, lack of recording of members who drop out lays AA's numerical effectiveness open to question."

He further suggested that AA's reluctance to study failures may "detract from AA in the sense that study of failures could lead to even greater effectiveness for AA."

The different treatments in the study were based on different assumptions about human nature, he explained, with rational behavior therapy emphasizing training in rational thinking and the assumption of responsibility for an individual's own destiny, insight therapy concentrating on an alteration in emotional life through the recognition and elimination of 'hang ups', and AA relying on "fellowship, surrender, and recourse to a higher power."

Follow up studies should provide additional information about the effectiveness of treatment, not just the holding power of a particular therapeutic group, he stated.

Study pinpoints sex differences

Female alcoholics harbor guilt

MANY WOMEN drink because it gives them energy and makes them "full of pep" and "lively".

But at the same time, they may feel guilty and depressed about their drinking, and worthless and useless.

In these areas, female alcoholics differ from male alcoholics and the identification of such differences may have important bearing on the type of treatment best suited to the female alcoholic, according to Dr. John S. Tamerin, director of research, Silver Hill Foundation of New Canaan, Conn.

Since women view themselves as troubled and symptomatic, they should be more receptive to psychotherapy than alcoholic men who do not see a relationship between their drinking and psychological factors, said Dr. Tamerin.

He reported that slightly more women than men had been admitted for treatment to Silver Hill, a private psychiatric hospital, since 1972. This, he said, emphasizes the importance of identifying characteristics which might be peculiar to the female alcoholic.

A study of 40 patients—20 men, 20 women—showed that, when sober, both groups characterized themselves as dependable, kind, friendly, and able to work.

However, he said, more of the women were self-deprecating, troubled by their conscience, and ashamed of their drinking.

While many of the women patients considered themselves gay and lively and even grandiose while intoxicated, they also tended, on the whole, to consider themselves worthless and useless to a greater degree than did the men, he said.

The spouses of the alcoholics were also surveyed and tended to agree with the alcoholics' self-descriptions while sober, but not while intoxicated, he reported.

For instance, wives thought their alcoholic husbands were more moody, depressed, angry, and confused than the husbands did while the husbands of the female alcoholics characterized them as unhappy, irritable, contrary, weary, and confused rather than relaxed, friendly and gay as the wives described themselves, he said.

The prime difference between the male and female alcoholics appears to be that women are more likely to feel guilt and depression about their drinking than men, but during intoxication women appeared to get energy from drinking.

"Although pharmacologically alcohol is a CNS depressant, these data suggest that behaviorally, for the female alcoholic, it is perceived as a stimulant, a psychic energizer and a disinhibiting agent" he said. "In effect, the female patient treats depression and its accompanying feeling of guilt with alcohol."

Since women do see themselves as troubled, they should be able to accept psychotherapy and explore the relationship between their troubles and their use of alcohol, he said.

Also, the fact women see themselves as resentful while intoxicated and their husbands report they become irritable and rude suggests that many feelings, suppressed while they are sober, become apparent when they are intoxicated, he said. Psychotherapy, therefore, could help these women find other ways of expressing their hostility and negative feelings without becoming drunk, he said.

Such an approach is not apt to be successful with men who do not see themselves as psychiatric patients, Dr. Tamerin observed.

The finding that some men see themselves as "too conscientious" when sober offers a possible therapeutic approach if the male could be helped to see the relationship between his conscientiousness when sober and his irresponsible behavior when intoxicated, he suggested.

Mary Hager reports from the North American Congress on Alcohol and Drug Problems held in San Francisco December 13-18

Drinking problems emerge among addicts: Eagleville

A STUDY of the use of alcohol by drug addicts has shown that more than half of the group studied had actual or potential drinking problems.

Harriet L. Barr of the Eagleville Hospital and Rehabilitation Center in Eagleville, Penna., reported that 61% or 100 addicts were considered to have actual or potential drinking problems and that half of them, those who were heavy or problem drinkers at the time of admission into the narcotic addiction program, were considered to have both an alcohol and a drug problem.

Her preliminary findings from a long-range study of drinking by addicts identified five different patterns of alcohol use.

About one-third of the addicts at some time had patterns of "intake, motivation and sympatomalogy indistinguishable from those of alcoholic patients, while a second group drank as much and as often as alcoholic patients but without the psychological dependence or the symptoms, and a third group drank heavily but not continuously and showed the beginnings of alcoholic symptoms, she said.

At the other extreme were one-fourth of the group who had no history of regular drinking, and a smaller group of moderate drinkers, she noted.

She observed that the proportion of drug addicts who drank heavily prior to their admission to treatment was no greater than a sample from the general population but, she said, over half of the addicts had been heavy drinkers at some time in their lives with a daily average intake comparable with that of an alcoholic.

In fact, she added, "the amount of drinking reported by 52% of the drug addicts as their maximum is comparable to the quantities reported by alcoholics." Also, she continued, 52% of the addicts reported some degree of psychological dependence on alcohol and half of them had at least one symptom of alcohol addiction.

The study showed, she continued, that "if a drug addict drinks heavily, he is likely to drink very heavily." While 61% had been heavy drinkers at some period in their life, only 9% had been heavy drinkers below the alcoholic level, she added.

Family suffering can be a

NEW YORK'S Nassau County has an unusual approach to alcoholism treatment which seeks to help the family first.

Joseph C. Kern of the Nassau County Department of Drug and Alcohol Addiction observed that families are usually overlooked but that the family needs help because it is "debilitated, traumatized and trapped. The family is on the edge of a precipice feeling helpless and hopeless."

He contended that the 'family suffers in equal measure to the alcoholic" and consequently needs equal treatment but "too often we wait for the alcoholic to seek treatment and then perhaps involve the family as an adjunct."

He described a program in Nassau County in which the family is involved, whether or not the alcoholic member seeks help.

"Regardless of the outcome, as far as the alcoholic is concerned, we have at least had an opportunity to stabilize the lives of the family members," he said.

The family program offers three steps and is designed primarily for the wife of an alcoholic, he continued. First is an eight week session on alcohol and alcoholism, followed by a second eight week session on "Life is Worth Living" in which spouses experience and learn necessary skills for coping and enjoying. and a third, more extensive group therapy program, for those who need more intense work.

He reported on 149 spouses who had been involved in the family program since its inception in June, 1973. Of these, 93% were women and 7% men, he added, with a range from 21 to 73 years of age. A quarter of the group were under 32 years of age.

He described the "typical" spouse as about 40, married for 17 years, married in late teens or early twenties, Roman Catholic and white.

They were, he observed, usually ignorant of alcohol and had a "fantasy" they could rescue their husband. They typically denied feelings, were submissive, had low self-esteem, had limited life experience, were dependent had a role conflict regarding their femi-

Dr

WHEN AN adolescent becomes addicted to drugs or to alcohol, his particular role within the family framework may be critical to his addiction, and to his treatment.

Consequently, the entire family, and not just the addicted individual, should be treated for, as David J. Huberty, coordinator of detoxification and halfway house services for the Central Minnesota Mental Health Center in St. Cloud, explained, "the drug abuse evolves into an integral part of the delicate balance of the family."

At the point that a family adjusts to drug abuse by one of the members "the family has a major psychological investment in maintaining that person as a drug abuser so as to not upset the family pattern," he continued.

"Psychologically," he said, "the most effortless way for most families to respond to the behavior that they now have an investment in is to scapegoat and chastise the adolescent for his drug abuse, conveniently failing to see that they play supportive roles in the drama."

He cautioned that failure to involve an entire family in treatment will result in every member "in some way sabotaging the efforts of the treatment staff."

Huberty noted that the drug abuser is a symptom of a problem family and that he will typically revert after treatment if he returns to his same role in the same family environment.

He identified seven areas in which he feels the adolescent abuser and the family often share "separate but similar problems." Once one of the problems is identified in the adolescent, it is "safe to assume" a similar problem exists in the family for they "fit together like a puzzle," he added.

These seven problem areas were:

Ignorance of chemical dependency

The family is ignorant of the effects of certain drugs as is the

Childho

HOW WOULD an addict describe his childhood?

If he were white and from the middle socio-economic class, he would say his natural parents were married and living together, but that they weren't compatible and failed to provide the love, trust, affection, attention and recognition he needed.

He would also say he didn't like his father, who showed him little affection, that he didn't get along well with his childhood peers, and

rug abuse a family affair

adolescent whose knowledge is limited to subjective experience. Some families blame drugs for all of an adolescent's problems while others fail to realize that the abuse of drugs could contribute to problems, he said.

Since the family is invariably bewildered, he continued, and the adolescent has limited, often faulty, information, factual information about the effects of drugs, chemical dependency and the process of rehabilitation can be beneficial.

Denial of chemical dependency

The adolescent may deny that a problem exists or does not believe that the problem exists for all drugs, an attitude often shared by parents who do not believe prescription drugs and alcohol are problems.

"Both parties have great difficulty in understanding that the drug abuser gets hooked on a high, a way of feeling good about himself that is an alternate state of consciousness which also provides a guaranteed mechanism of avoiding problems and pain," Huberty continued.

Parents often encourage an adolescent to change drugs, but once the abuser understands about chemical dependency, he will see alcohol as a problem more readily than his parents do, he added.

Failure to accept responsibility

Abusers tend to blame parents rather than accept blame for their own behavior, just as parents and other family members cover up or try to cushion the consequences. Frequently both sides look for an external factor that will leave them guilt-free, he noted.

Anger and hostility, love and affection

By the time an abuse problem is identified, the abuser has successfully repressed anger, hostility and the ability to express emotions. Both sides avoid strong emotions, either love or anger, and "getting high provides the adolescent a mechanism by which he can experience a release or explosion of intense feelings whether they be anger and hostility or love and affection," Huberty explained.

Drug abuse and bad behavior often provide "a spark of life" in a dead emotional relationship, and as such provide a crisis that is "welcomed psychologically" in an emotionally starved family.

Ambivalence

Both sides possess conflicting feelings, with the abuser often expressing hate for his parents, but also feeling love, and the parents feeling disgusted by the abuser but denying that they feel anything but love.

The adolescent may be ambivalent about his use of drugs, at times wanting to stop and at times wanting to continue, while the family, too, may be ambivalent about keeping the abuser in his dependent role or letting him go, Huberty said.

Lack of honesty

The adolescent has been used to distorting the truth and rationalizing his behavior, while the family has adjusted to his dishonesty and responded with dishonesty by covering up for him.

Role model for drug abuse

The parents frequently provide the model for taking drugs, he noted, reporting his observations that 50% of adolescent drug abusers come from families with a history of alcoholism or some other form of substance abuse.

He suggested that therapy should aim at helping family and abuser understand the interlocking problems so that they can all accept each other as individuals who "happen to have some mutual problems." The "mutuality", he emphasized, is the "heart of the treatment effort."

The consequency of therapy should be the "emancipation" of the adolescent and the development of an "adult-to-adult" relationship in place of the former "parent-to-child" relationship.

Failure to involve the family can lead to considerable pressure from the family to reverse any change in an adolescent's behavior, he warned, noting "it is precisely this resistance to change that counsellors are constantly up against in treating the adolescent drug abuser and this is why his treatment must truly be a family affair."

NIDA study

Adolescent drug users drink more

ADOLESCENTS WHO use drugs also drink more, smoke more, use more over-the-counter medications and have more psychosomatic symptoms than their non-drug-using contemporaries.

These apparently related traits emerged from a comparison of the characteristics of drug users and non-drug users in 79 different high schools in 10 cities. The study was conducted by the Institute for Research and Evaluation in Hempstead, NY, for the National Institute on Drug Abuse.

J. R. Block, who headed the study, reported that drug users tended to be less religious, showed a greater sense of alienation from their parents, and were not doing as well in school as their drug-free contemporaries, he said.

More of the drug group was male and white and the median family incomes for the group were approximately $1,500 higher than in the non-drug group, he added. The non-drug users also tended to be non-drinkers, he continued.

The survey showed that 47% of the non-drug group had never had a glass of beer compared with only 7% of the drug group.

For wine, the figures were 46% and 7% and for hard liquor 72% and 19%, he said.

An analysis of the students in both groups who said they drank, showed the drug users drank more frequently than the non-drug group, regardless of the particular type of alcoholic beverage. Also, 62% of the drug group said they had been "high" on alcohol within the past month in contrast to only 13% of the drinking non-drug users, he said.

Patterns of cigarette use were similar to those for alcohol, with 64% of the non-drug group saying they had never had a cigarette compared with 18% of the drug group.

Only 26% of the non-drug group said they smoked at least one cigarette a day, while 64% of the drug group smoked at least that much. He noted that "consistent with their drinking behavior, drug users are more likely to smoke and among those who do smoke, they seem to smoke more". He noted that the smokers in both groups started at an average of 12 years, 6 months.

Students were asked about their use of 17 common over-the-counter medications, including stimulants, tranquillizers, hypnotics, pain killers, cough syrups, and stomach calmers, in the past year, he said.

Of all the drugs, four pain-relieving medications, all forms of ASA, were the most frequently mentioned, Block said.

When use between the two groups was compared, the drug users were found to use the over-the-counter medications more frequently than the non-drug group.

Related to this self-medication was the fact the drug group reported that such symptoms and conditions as headaches, pains, coughs and colds, and upset stomachs, occurred with relative frequency, he continued, and the difference between the drug group and the non-drug group was "quite substantial".

The drug users also reported more frequent use of pills and medicines to combat the symptoms than the non-drug group did. This suggests "users of illicit drugs either have more of the symptoms and conditions asked about or are more likely to take medication (or take it more frequently) than students who are not involved in the use of illicit drugs," said Block.

He reported a "striking consistency" in the findings from the different types of schools.

One conclusion that could be drawn is that drug abuse is a "poorly understood behavioral phenomenon" and the differences demonstrated between non-drug users and drug users in personality, attitudes, and life style could play a significant role in treatment, education, prevention, and intervention programs, he said.

"It is indeed clear and obvious that the drug group was at one point a non-drug group and there may well be a critical point of intervention that could serve to keep the groups drug-free," he suggested.

Last year's survey also found some interesting facts on the effect of drug education programs.

"Exposure to a drug education program was associated with a slightly higher incidence of drug use and a somewhat poorer knowledge about drugs," the report says.

"It was also found that students who felt that their own experience was their best source of information about drugs were proportionally more knowledgeable and more likely to use drugs than students who stated that their best source of information came from the media, schools or their friends' experiences.

"It was also found that the more knowledgeable a student was, the more likely he was to use drugs."

hood portrait of an addict

usually disagreed with his parents and teachers.

His parents, he would say, set few limits on his behaviour, but when they did punish, it was apt to be inappropriate and harsh.

And he would say he was dissatisfied with himself as a child, did not think he could live up to the expectations of others, was not close to his family, found his home life unpleasant and wanted to leave home at an early age.

This description emerges from a study of the self-concepts of 70 white, middle-class addicts reported here by Dr. Richard A. Lindblad, director of program development for the National Institute of Drug Abuse (NIDA).

The addicts, who came from two different parts of the country, were subjected to several self-attitude tests and were matched with controls given the same tests.

Self-attitudes, Lindblad explained, are an individual's evaluations of himself which are probably fixed in early adolescence and change little during the years.

Tests showed the addicts in the study were nearly eight times more likely to have negative self-attitudes than the non-addicts although, Lindblad emphasized, "merely having negative self-attitudes does not imply that addiction will follow".

The study identified a number of factors in childhood and adolescence which seemed to discriminate addicts from non-addicts and which "support the contention that addicts possess negative self-attitude prior to addiction," he continued.

For instance, he said, controls more frequently reported having compatible parents while addicts more frequently reported living with someone other than their natural parents during childhood and wanting to leave home at a significantly earlier age.

Controls also more frequently perceived loving parents who knew their friends, were interested in their school performance, and attended school events, he said. The controls tended to like their mothers and fathers, recalled childhood mealtimes as pleasant and communicative, were close to their siblings, and generally agreed with their parents, teachers and classmates.

Controls tended to have more above average grades in high school than addicts and had a significantly greater number of close friends during the high school years.

They also reported more frequently that their parents set weekend curfews and that they thought their parents trusted them during childhood, Lindblad said.

He suggested the "unique background traits" of the white middle-class addict which emerged from the study might provide a key to future preventive measures.

"This small study does suggest that negative self-attitudes might be a necessary condition in the etiology of addiction and thus imply that drug addiction prevention might well be focused at the antecedent variables leading to positive self-concepts," he concluded.

verted

ninity and underestimated the impact of alcoholism on their children.

Those particular problems became the focus of the family services programs.

Kern noted a change in the spouses who went through the program.

Once treatment was completed, he said, "worry has been replaced by hope; despair has been lessened with a new ability to enjoy the bright moments in life; self-esteem has been elevated with skills at hand to make decisions; options have been opened with an awareness that she has power and control to direct at least some aspects of her life."

Alcohol on campus

CONTRARY TO expectations five years ago, alcohol has become firmly entrenched as the favorite "drug" of United States college men.

A study of 834 men, surveyed first as freshmen in the autumn of 1970 and again in the spring of 1973, showed a significant increase in heavy (three times a week or more) use of alcohol but no change in heavy use of marijuana.

Five years ago, people were frightened about the use of marijuana and heroin, said Glenn D. Mellinger of the Institute of Research in Social Behavior, Berkeley, California.

Alcohol was then thought to be "irrelevant", he said.

Study showed that nine of 10 of those surveyed used alcohol or marijuana or both but that only 26% could be classified as heavy users of either substances.

At the time of the first survey, 56% had used marijuana in the past year (63% in 1973) and 85% had used alcohol (89% in 1973).

Two thirds of the marijuana users had used only marijuana and three fourths of the alcohol users had used only alcohol and that was almost entirely in the form of beer or wine.

A different picture, however, emerged in terms of frequency of use.

As freshmen, 13% of the marijuana users used the drug three or more times a week while only 6% of those who drank used alcohol that frequently.

No change was noted in the number who used marijuana frequently in the second survey but the incidence of frequent use of alcohol had jumped to 17%, he said. This, he added, did not necessarily mean the substance use caused problem behavior.

A high incidence of use of both substances was also noted.

In the first study, 84% of the marijuana users said they also used alcohol. By 1973, the figure had risen to 95%, he said. In both surveys, 60% of those who drank alcohol said they had also tried or used marijuana, he added.

UK physicians:

Cigarette makers should pay "victims"

By ALAN MASSAM

LONDON—The notion is slowly catching on in Britain that commercial interests making profit from the sale and distribution of "harmful" products should carry greater responsibility for the consequences.

Dr David Owen, Minister of State, Department of Health and Social Security, is known to view sympathetically a proposal that cigarette manufacturers should be liable for compensation in respect of damage caused by smoking.

The initiative has been taken by the Royal College of Physicians' pressure group Action on Smoking and Health (ASH)*

It has submitted to the Royal Commission on Civil Liability and Compensation for Personal Injury a plan for setting up a compulsory insurance scheme for smokers, financed by a levy on the price of cigarettes.

A levy of 3 pence (about 7 cents) per cigarette pack, ASH calculates, would raise in Britain at least £210,000,000 (about $525,000,000) per year, while a 5 pence levy would raise £350,000,000 ($875,000,000) annually.

"Such sums, bearing in mind the Department of Health and Social Security estimate of 52,000 cigarette-associated deaths annually in those aged 74 and under, would not be excessive," says ASH.

Executive director of ASH, Mike Daube, commented: "It's time to start placing the responsibility for the damage to life and health caused by cigarettes firmly with the manufacturers.

"If they encourage people of all ages to smoke, they must face the consequences. It is also time to think about the smokers' problems: it may well be that a levy on cigarette packs will provide much needed compensation, and we hope the commission will take up this recommendation."

ASH claims there is evidence to indicate that many smokers become addicted before they reach an age when they might make a rational judgment about the dangers of smoking.

It stresses that once a smoker is addicted his smoking may no longer be "voluntary" activity. (M.A.H. Russell, British Medical Journal 1971, 2,330, says: "A teenager need smoke only twice to have a 70% chance of smoking for the next 40 years if he lives so long.").

It appears that even belatedly increased health education and warnings are insufficient to prevent children from starting to smoke before they can comprehend or make reasoned decisions about the hazards involved. Many of those who attempt to give up smoking at a later age are unable to do so.

Turning to the marketing of tobacco products, the ASH submission pulls no punches. It says: "The cigarette manufacturers have marketed and promoted cigarettes for many years with little evidence of concern for the public health. . . . The manner and magnitude of their promotions have been of such a level as to be liable to influence both smokers and non-smokers.

"Some of the characteristics most frequently named by children as being 'positive' reasons for smoking are consistently used in cigarette advertising and promotion."

The ASH submission argues that although the manufacturers have been aware of the harmful consequences of smoking for many years "it appears that their concern has, unless otherwise forced by external pressures, all too often been to prevent the consumer from being disturbed by thoughts of ill health."

"Such restrictions as exist on the marketing and promotion of cigarettes and such provision of information and warnings as exist on cigarette packs and advertisements result from ministerial and public pressures, and might have been stronger with more co-operation from the industry.

"The industry has found means of circumventing both legislation (e.g television advertising of cigarettes) and voluntary codes of practice. The manufacturers have, in our view, wilfully ignored the protective spirit of both legislation and voluntary codes of practice."

ASH concludes: "*There has at no time been a genuine attempt by the manufacturers of their own volition to warn consumers of the dangers of smoking, to discourage smokers from smoking more, or to warn prospective smokers of the risks involved.*"

ASH then acknowledges that British law does not accept the possibility of strict liability (liability where no specific fault can be proved) when a potential defendant voluntarily introduces an inherently dangerous product, but again stresses that smokers incur a risk which is not always voluntarily accepted because at the time when they became addicted to cigarettes they may not have been capable of appreciating the risks involved.

It is possible that the law of negligence would permit an action by the deprived widow of a smoker, "but no such test has arisen . . . It is our view that there is a need for clarification of the law."

Finally, ASH submits: "Manufacturers who have attempted to ensure heavy sales of an inherently dangerous product should bear responsibility for damage caused by their products if those products are used in such a way as the manufacturers might reasonably have anticipated.

"It should be for the manufacturer to prove that any injury suffered as a result of the use of his product could not have been expected when the product was supplied, and/or that he has made every reasonable effort to ensure protection of the consumer. Thus tobacco manufacturers should be liable in principle for compensation payable in respect of death or damage to health caused by cigarette smoking. It is our view that the State should make it plain where responsibility in this matter lies."

*Action on Smoking and Health 79, York Rd., London SE1.

Alcohol not the only rogue on the road

By JOHN DORNBERG

COLOGNE—Alcohol may still be the major villain on the highways, but according to a West German psychologist, it is by no means the only one.

Experts on road safety, says Dr. Liselotte Moser of the National Institute of Traffic Affairs here, are only gradually starting to realize the perils of tea, coffee, nicotine, medicines and "soft" drugs.

Dr. Moser, who has recently completed a study of the dangers of drugs and stimulants to motorists, reported on one accident where a driver lost consciousness and control of his car after imbibing eight bottles of Coca Cola at rest stops on a long journey.

Although her research included all stimulants, it focused primarily on "soft" drugs and medication.

It revealed that 71% of regular hashish smokers had driver's licences and of that group 77% had driven frequently after smoking pot. Some 67% of the hashish or marijuana users who drive admitted that they are more easily distracted and tend to lose concentration at the wheel after smoking.

They said their reactions were slower, that they found steering more difficult, their powers of observation and reasoning diminished and admitted to making "twice as many mistakes" at the wheel.

"Hashish and marijuana," says Dr. Moser, "appear to be approximately as dangerous on the roads as alcohol. As with alcohol, the amount consumed is important. The normal dose of about one gram of hashish produces about the same effects as 0.8 parts per thousand alcohol in the blood (the legal driving maximum in West Germany)."

In Muenster a pharmacological research team is currently working on the development of a rapid on-the-spot test for hashish intoxication to be used by police. It consists of a chemically coated piece of paper which changes color when exposed to saliva.

Dr. Moser suspects, however, that by far the greatest drug danger on the roads is caused by medically prescribed drugs.

"I estimate," she says, "that about 10% of all accidents occur under the influence of medication."

The West German Automobile Club (ADAC) goes even further than that. It believes that prescription medicines account for as many as 15% to 20% of traffic accidents.

Although the West German state governments have the authority to require pharmaceutical manufacturers to print warnings on their drug packages if they are potentially dangerous to driving, none of the states has made use of this authority as yet.

Meanwhile the pharmaceutical industry itself has published a list of 257 potentially hazardous tranquillizers, sleeping pills, pep tablets, psycho-medicines, reducing pills, anti-allergents and blood pressure medicines.

The list points out various side effects such as tiredness, aggressiveness, apathy or impaired performance.

Anti-drug campaign for Bavaria

MUNICH—The Bavarian state government has launched a campaign in the seventh to ninth grades of all public schools to warn and educate pupils about the dangers of drugs.

The aim is to reduce the number of children who experiment with drugs because they want to see what it is like to use them.

The drive, sponsored jointly by the ministries of education, interior, justice, and social welfare, calls for a statewide quiz on the problems of drug usage. Classes scoring best in the quiz will be asked to produce skits and art work dealing with the drug problem for subsequent showing on educational television.

The plays and art will be judged by all school children in the 12- to 14-year age group and prizes will be awarded to the classes with the best ideas and most original performances.

The Inter-ministerial Study Group for the Fight Against Drug and Narcotics Abuse, which has organized the campaign, sees the program as a potentially very effective tool to reduce the number of youths who will experiment with drugs "just for kicks", and then be drawn into the hard core of regular users.

A 1973 survey revealed that some 220,000 young people in this state of 11 million population had tried drugs and that about 80,000 used narcotics of one form or another regularly. Most of them had been exposed between the ages of 12 and 14.

In the past two years, according to the study group, there has been a pronounced reduction in the popularity and status appeal of drug usage among teenagers. Moreover, the total number of addicts has not increased and there is even evidence to suggest a decline.

What worries the group, however, is that the pattern of those who experimented with drugs in earlier years, only to become dependent or addicted, has not changed markedly.

As part of the drive, the Bavarian authorities will give widespread distribution to parents of a pamphlet recently prepared by the West German federal ministry of health.

It explains why youths, in particular, turn to drugs and offers advice on what can be done against it.

The pamphlet contends one of the main reasons for youthful drug consumption is the flippancy with which the subject is treated, often by parents. It places considerable blame on the pharmaceutical industry for attempting to convince customers that prescription-free pain-killers, pep-pills and sleeping tablets are harmless.

Parents who "pop pills" and grab for the medicine bottle at the slightest sign of discomfort, the pamphlet stresses, are in effect inducing their children to emulate them and engage in experiments that could lead to serious dependency and addiction.

Alcohol consumption among West German youth is especially alarming. According to one recently published survey by the Bavarian ministry of interior, 53% of all youths between the ages of 12 and 24 consume alcoholic beverages daily.

Of 12- to 14-year-olds, 8% drink spirits regularly.

ADDICTION PREDICTION

LONDON — A five-year research study has been set up at the University of Oxford with the objective of identifying personality characteristics predisposing to addiction.

The man given this formidable task is pipe-smoking Dr. Gordon Mangan of the university's department of experimental psychology.

Dr. Mangan, a New Zealander, has received a £33,000 (about $82,000) grant from the Social Science Research Council and will concentrate his attention on the development of the smoking habit. He wants to know why children start smoking and why they continue once the dangers have been pointed out.

Currently, Dr. Mangan's study will concentrate on establishing the personality traits of between 700 and 800 Oxford 13-year-olds.

Two years later he will interview them again (age 15 is regarded as the peak age for starting to smoke) to see if any particular traits are common to the smokers.

Dr. Mangan said one valuable outcome of the study would be to establish ways of identifying young people "at risk" from smoking before the habit actually begins.

Around the world

DRUZHINIKI

Soviet policemen are to receive increased assistance from civilian auxiliaries who until now have dealt mainly with the drunk and disorderly. Under a new decree by government and party leadership, the auxiliaries—druzhiniki in Russian—will have an expanded role in combating crime in general. The druzhiniki, identified by red armbands, are not salaried but receive such rewards as preferential treatment in obtaining housing and discounts at health and vacation resorts in recognition of their efforts. New duties include exposing people who are home brewing liquor.

OPIATES

Hope of synthetics replacing opiates is an "illusion", according to a Greek scientist. Prof. Georges Lagaras of the University of Thessalonica told the United Nations Narcotics Commission he was glad to hear American colleagues changing their outlook.

"We must draw lessons from history," he said. "Many strong analgesics have been introduced in the past with the assurance that they would not lead to dependence.

ALARM

The International Narcotics Control Board has warned that the abuse of drugs "still continues to grow at a disturbing rate". There has been a "noticeable increase" in the use of drugs in multiple combinations while the use of more concentrated and potent drugs has become "alarming", the board said in its annual report from Geneva. Particular concern was expressed over the "substantial quantities" of liquid cannabis now appearing.

SMOKING

Smoking among West German pre-teenagers has assumed such alarming proportions that the Federal Health Education Institute has commissioned a team of researchers to study the problem. According to the institute's preliminary report, 36% of all German schoolchildren smoke—either furtively at home or flauntingly at school on the playground or quadrangle. For one in three of them it is a "mark of adulthood" and a boost to self confidence.

INTOXICATION LAW CHANGE IN MICHIGAN

By JOSEPH GRIMM

PUBLIC INTOXICATION is to be treated as a treatable disease rather than a punishable offence in Michigan.

The new approach is the result of House Bill 40028 signed into law by Michigan's governor, William Milliken, late last year.

Under the new law, people will be considered incapacitated if they have become intoxicated, unconscious, or substantially impaired either physically or mentally, through the use of alcohol.

Incapacitated people picked up by police or emergency service units, will be taken home, to an agency approved by the Office of Substance Abuse Services, or to an emergency medical service. Intoxication itself will no longer constitute grounds for arrest or a police record.

Treatment under the new law will include diagnostic evaluation, and medical, social, psychological, psychiatric and social care.

Incapacitated people arrested for committing a crime such as reckless driving or any other misdemeanor or felony, will be treated in the same way although they will still be held responsible for their criminal or civil offences.

People directed to such treatment programs will not be detained for more than 72 hours or after they are sober.

The law will not become effective immediately. A voluntary two-year phasing-in period will last until January 1, 1977. From that time, no local laws may be passed or enforced in Michigan that make public intoxication a crime.

House Bill 4008, which was submitted in January, 1973 was redrawn from an earlier bill that failed in the state's House of Representatives. The first bill was submitted in early 1972.

Liver research work

(from Page 1)

affected certain chemical reactions in the brain.

The research showed that experimental animals regularly given heavy doses of alcohol developed marked increases in the activity of a specific enzyme (ATPase) not only in the brain but also in the liver.

This enzyme acts on a cell component, ATP, and breaks it down to a substance called ADP which acts as a sort of "thermostat" or "rate setter" for the liver's oxygen demands. The greater the rate of ATP breakdown, the faster the liver works to metabolize the alcohol, and the more oxygen the liver needs.

This increased oxygen demand is particularly important, say the scientists, as alcoholics often also have subnormal oxygen blood levels.

They tend, for example, to have moderate degrees of anemia; they sometimes have inadequate formation of blood cells in the bone marrow; and they often have respiratory problems, especially if they are heavy smokers.

If they have been drinking heavily and losing blood from gastritis and other gastrointestinal lesions, they may have additional cause for impaired oxygen-carrying capacity.

Another phenomenon which makes the liver vulnerable to reduced oxygen conditions is the anatomy of its blood supply.

The liver receives blood from two sources, the hepatic artery and the portal vein. After passing through the gastrointestinal system on its way to the portal vein, the blood loses much of its oxygen supply.

Consequently, the liver must also be dependent for oxygen on the blood supply from the hepatic artery.

This is more important in some species than in others. In the human being, the hepatic arterial supply is relatively small compared to the portal venous blood. In effect, the human has a low "margin of safety" making him vulnerable when increased oxygen demands are placed on the liver—as when alcohol stimulates an increased metabolism.

Each branch of the hepatic artery supplies a small portion of the liver known as the liver acinus. Within each acinus, cells are arranged in short parallel cords with the blood passing down their entire length. By the time the blood passes down the cord, much of the oxygen has been absorbed and the cells at the far end do not receive enough.

These factors, added to the delicate "margin of safety" put the heavy drinker at risk.

One major problem that has to date hampered studies of alcohol's effect on the liver has been that the rat, unlike the human, is well supplied with oxygen through the hepatic artery. Thus, it has a much higher "margin of safety" than has man.

Regardless of the amount of alcohol given to experimental animals, the supply of oxygen via blood flow in the liver has always remained adequate to service the cells. Consequently, the researchers sought means to develop an experimental technique in which animals could be studied in conditions of diminished oxygen supply.

In one series, animals were exposed to low oxygen environments. In other work by the team, some rat blood was drained and replaced with plasma but not the oxygen-carrying red cells; and in another series of experiments, the hepatic artery was tied so as to cut oxygen flow from that source.

In all of these experiments the intent was to reproduce a state of lowered oxygen supply, thus reducing the "margin of safety" and producing a situation more comparable to that in man.

Groups of these animals were given diets controlled for calories, proteins, fats, and sugars. One group received alcohol, the other did not.

The animals which received the alcohol and were then placed in an oxygen-reduced atmosphere, developed lesions in the liver remarkably similar to the lesions found in humans with alcoholic hepatitis.

On the other hand, no significant cellular change was found either in the alcohol-treated animals exposed to normal amounts of oxygen, or in the control animals, even in the low-oxygen atmosphere.

These lesions ranged from the mild cellular damage representative of alcoholic hepatitis, through to massive death of cells with bridging between central veins (believed to trigger the cirrhosis scarring).

The researchers found that as the oxygen supplies to the experimental animals were reduced, the lesions became more severe.

These findings fit clearly into a continuum of previous research work by the Toronto group in which similar changes in enzyme activity, increased metabolism, and increased oxygen-consumption, occurred in livers of animals treated with thyroid hormones just as they did in animals treated with alcohol.

The connection may be quite direct because the investigators found that alcohol actually increases the amount of thyroid hormone entering the liver from the blood.

The researchers found that a short pretreatment with PTU (which reduces the amount and activity of the thyroid hormone) reduced to normal the liver's rate of metabolism, and markedly reduced the tissue damage in the alcohol-drinking animals, caused by the failure of oxygen supplies to meet cellular demands.

Animals treated for as little as three to 10 days with PTU no longer showed any evidence of abnormally high metabolism or cellular damage.

The researchers indicate that if the hypothesis is correct, the same action of PTU might also have practical value in treating liver cell damage associated with other conditions induced by inadequate oxygen supplies.

A scientific report on the low-oxygen animal work related to these studies is scheduled to appear in the March issue of the Proceedings of the National Academy of Sciences (U.S.).

Dr. Israel's co-workers in this series, in addition to Dr Kalant, were Hector Orrego, M.D; Jatinder Khanna, PhD; Luis Videla, MSc; Jaime Bernstein, PhD; Neva Woo, MSc; and James Phillips, MD.

....More letters

(from page 6)

narcotic in his possession), and after the close of the case for the prosecution and after the accused has had opportunity to make full answer in defence, the courts will make a finding as to whether or not the accused was in the possession of a narcotic contrary to section 3."

"If the courts finds that the accused was not in possession of a narcotic he shall be acquitted; but if the court finds the accused was in possession of a narcotic contrary to section 3 he shall be given an opportunity of establishing that he was not in possession of a narcotic for the purposes of trafficking, and thereafter the prosecutor shall be given opportunity of adducing evidence to establish that the accused was in possession of the narcotic for the purposes of trafficking . . . and if the accused fails to establish that he was not in possession of the narcotic for the purposes of trafficking he shall be convicted of the offence as charged."

This has been the law for a number of years. I suggest that in one sense his article is misleading, as if this was a new concept. Possibly this could be clarified.

Eric L. Teed
TEED and TEED
Saint John
New Brunswick

'BREATHALYZER'

Sir:

I am somewhat concerned and disappointed by Walter Nagel's article on portable breathalyzers in **The Journal**, (Dec. 1, 1974).

First, I am concerned over the use of the name Breathalyzer being used to apparently describe a number of breath testing devices. The name "Breathalyzer" is a trade mark of the Smith and Wesson Company and not a generic term. New Hampshire's statewide breath testing program utilizes the "Breathalyzer Model 900A". The article, by incorrectly using this term to describe other devices and then describing them as "proved unreliable", could have an adverse effect on the admissibility of evidence obtained by the use of the Smith and Wesson instrument.

Second, I am disappointed because Mr. Nagel does not identify the unreliable devices. We are evaluating several portable screening devices in the state and the information presented would be very useful to us if we knew what equipment was involved in the Calgary tests.

John M. Muir, Director
Alcohol Safety Action Project
Concord, New Hampshire.

'APHRODISIAC'

Sir:

I am writing in reference to your article "To Enhance Sex Marijuana is 'Unparallelled'" (**The Journal**, Feb. 1, 1975).

I have subscribed to **The Journal** because I consider it to be a professional journal. To me this article smacks of "newspaperism" and is out of place in this publication.

I am aware that a thorough reading of the article adequately puts it in the category of a non-scientific speculation, but this is just the type of article the "popular press" tends to use as an eye catcher. Anyone who has researched the area is acquainted with the general lack of "aphrodisiac effect" in drugs in general. At the same time, a sample size of 95 non-random individuals is not going to be considered worthy of discussion. What worries me is the possibility that individuals without this kind of training might consider this information as valuable and use it in that way.

I enjoy the relaxed format of **The Journal** but I feel the editorial staff has a great responsibility to consider the broad ramifications of any article appearing under its byline. To the uninformed this article would certainly encourage experimentation with marijuana, when in fact we are a long way from being able to classify it either as harmful or not harmful.

I enjoy **The Journal** and find it very valuable in keeping abreast of the "going ons" in the field. Please consider this letter as a constructive criticism not a castigation.

Charles H. Clay, Consultant
Drug Education
Fraser Public Schools
Fraser, Michigan

SMOKERS

Sir:

As a non-smoker for the last year, I have been watching **The Journal** with some interest for reports on the involvement and success of jurisdictions in North America in helping people quit smoking. I note that there are now a substantial number of private enterprise clinics and techniques designed to help people quit, and I suspect that this is an area of lifestyles and addictions which can be greatly influenced by a relatively modest amount of spending by government. Not only can they help fund clinics, they can also affect lifestyles by requirements such as the extension of non-smoking areas in public transit, airplanes, elevators, and restaurants, etc.

It is a fruitful field for public policy and I suspect that the public is open to these approaches and more prepared than in the past to take the question of non-smokers' rights seriously.

As an MPP in the Ontario Legislature, I would be very interested in news of successful anti-smoking programmes either by government agencies or by private institutions, or for views on the most promising techniques for legislation in order to help reduce the incidence of smoking in the public.

Michael Cassidy
MPP—Ottawa Centre
Parliament Buildings
Toronto, Ontario

'MISFORTUNE'

Sir:

Industrial alcoholism, traffic deaths, and self-induced health problems are all related to alcohol abuse.

Of course, we believe that none of these misfortunes can happen to us.

They can.

William E. Rae
Scarborough, Ontario

NMUD treading water pending pot decision

By BRYNE CARRUTHERS

OTTAWA—In limbo following publication of the final LeDain Commission report on drug abuse in Canada and the government's proposals to change cannabis laws, the non-medical use of drugs directorate (NMUD) in the federal health department has been left treading water.

Health Minister Marc Lalonde is still "considering" a NMUD report on suggested government action in the drug area in response to the requirements set out in the final LeDain Commission report. Little, if anything, is expected to happen until the fate of the cannabis legislation now before the Senate is settled.

And the NMUD unit (now called the non-medical use of mood-altering substances directorate, to encompass alcohol and cigarettes) is still trying to follow-through on some important changes in emphasis and direction that had been in the works before the LeDain Commission's final report: namely, the swing to more emphasis on alcohol, as opposed to cannabis and illicit drugs; and a move to increase the emphasis on trying to prevent drug abuse (such as by modifying lifestyles, Lalonde's own campaign which attempts to get people to get busy doing something else so they won't have the time nor the inclination to abuse drugs) as opposed to the time-honored educational-informational campaigns designed to try and convince, sometimes scare, people not to use drugs.

The federal government spending estimates for 1975-76, made public recently, suggest that the NMUD unit was being given a stand-still budget to go with its water-treading activities.

The spending estimates tabled in Parliament showed the budget for drug abuse increasing a dismal 0.78%, from $9.59-million to $9.665-million next fiscal year (which starts April 1).

And the money available to support research and anti-drug abuse activities outside the government had actually been reduced by 7%, from $6.56-million this year to $6.1-million next fiscal year.

But **The Journal** has learned that finances are not quite that bad.

Due to an $800,000 item hidden elsewhere in the federal spending estimates, NMUD will actually come out $334,000 ahead on its grants and contributions next year.

The money devited to supporting summer scholarships for students doing drug research and to providing community development agencies with extra money to hire students for anti-drug abuse-related projects will increase from a total of $790,000 this year to $800,000 next year. In the spending estimates "Blue Book," the $790,000 item looks like it is being dropped altogether next year, with no replacement. But the $800,000 (half for summer scholarships and half for student hiring) is listed under the Treasury Board's budget, since it was late in being approved.

The $100,000 in this year's budget devoted to information-education programs that also looks as though it has been dropped for next year has in fact been absorbed in the $4-million grants program in support of innovative projects. That budget then has not increased one penny.

But the budget for contributions to support sociological and biomedical studies in the drug abuse area has been increased by $334,000, or more than 20%, to $1.854-million.

And health officials say that the emphasis within this grants program is switching away from biomedical studies on the effects of drug abuse towards more sociological research on the causative factors leading to drug abuse, and possible ways of preventing drug abuse.

These will include more epidemiological studies to determine the extent of problems associated with drug abuse, along with the psychological and behavioral aspects of treatment as well as some of the reasons for using drugs.

These studies are also focussing more on alcohol and less on the so-called "street drugs" namely cannabis. NMUD is now devoting about 35% of its total budget on alcohol. And the unit has been getting the most requests for information on alcohol problems in recent months, though the Senate committee hearings on the cannabis bill already seemed to have sparked a resurgence of interest in cannabis information.

The directorate is also responsible for the anti-smoking program of the federal health department and this is accounts for about 20% of the contributions from NMUD to outside researchers.

Despite the 10% increase in budget overall, NMUD officials agree they are really in a holding pattern. It's just enough to keep up with inflation.

"We really can't ask for more money until the Minister and cabinet decide on new initiatives and directions in the drug abuse area," one official said.

Students drinking more B.C. survey confirms

By PETER THOMPSON

VANCOUVER—Comparative surveys in Vancouver have come up with statistical evidence that most people realize intuitively: School children are drinking more alcohol while their use of other drugs has generally changed little.

These conclusions were drawn from comparing a 1970 and 1974 survey of drug use among Vancouver school children by the Narcotic Addiction Foundation of B.C.

The report, by John S. Russell and Marcus J. Hollander of the NAF says the results can be generalized to the entire population of Vancouver secondary schools.

About 71% of the students now use alcohol compared with 61% in 1970, according to the report. And 64% of the students reported smoking tobacco compared with 42% four years before.

The report warns, however, that slightly different wording of questions in the two surveys might account for the difference in the number of smokers.

The use of marijuana and hashish didn't show much change. Thirty-nine per cent used cannabis in 1970 compared with 42% in 1974.

Drug pamphlets in pharmacies

TWO MAJOR retail pharmacy chains in Canada are now dispensing drug and alcohol educational materials along with the more usual product—prescription drugs.

Health Education/Information Centres have been established at many of the Woolco Pharmacies and Shoppers' Drug Mart Stores in cities and towns across the country.

The stores offer as a free service a wide selection of brochures, many of them prepared by the Addiction Research Foundation. They expose consumers to vital information on physical and social consequences of alcohol and drug dependence.

"These two important retail pharmacy chains—and indeed the retail drug dispensing industry as a whole—have shown a commendable sensitivity to the costly implications of excessive chemical dependency," says H. David Archibald, executive director of ARF.

"The co-operation we have received from drug retailers should serve as a model to other influential industry groups."

An especially popular item with customers is the ARF publication, *It's My Life*, a 20-page booklet which takes an objective, non-moralizing look at drug abuse.

Materials from related agencies such as the Council on Drug Abuse, and other organizations in the field of general health and fitness are also featured in the centres.

Addiction workers

"People without a country"

By DOROTHY TRAINOR

MONTREAL—Despite the fact they have done much to fill a treatment vacuum created by the professionals' failure to cope with drug addicts, addiction workers are "people without a country".

This was the message brought to the 31st International Congress on Alcoholism and Drug Dependence in Bangkok by John Devlin, executive director of Montreal's Portage Program for Drug Dependencies.

He recommended that the addiction worker should have a new identity as "addiction therapist".

"His dilemma is that his position did not come about as a result of competent therapists requiring someone to function at a lower level—thus freeing the professional for more important endeavours," Mr. Devlin explained.

"Quite the contrary, he started as an alternate to the professional therapist. Despite this, he is denied recognition.

"This is primarily due to highly powerful and political pressure groups, such as the American Medical Association, who jealously guard their positions as healers of society."

Along with co-author, psychologist Peter Vamos, Devlin felt the time has come for both recognition and status for the addiction worker.

From the *Journal of Drug Issues*, he quoted Alexander Bassin as saying that the addiction worker either rejects his old colleagues with a vehemence that interferes with his efficacy as a change agent, or simulates the white collar professional to the extent of wearing a suit and tie and acquiring an attache case.

In either event, he becomes a marginal person, said Mr. Devlin.

Some favourable change is occuring however, he said, in that it is realized that a fruitful sharing can exist between the behavioural scientist and drug addiction worker. Furthermore, the need for the addiction worker is recognized both in the light of his successful effort and of insufficient professional manpower.

"Nevertheless, the majority of these para-professionals remain outside the bounds of professional recognition and sanction."

The solution offered by some professionals, said Mr. Devlin, is to train minimally lay individuals possessing the prerequisite personality traits. They only recommend, however, that lay helpers be employed as aides and assistants to release the professional from lower echelon duties.

Yet another group has recognized the direct therapeutic contributions lay people make and suggests letting results speak for themselves.

"In the case of the drug addiction worker, results have spoken overwhelmingly in favour of the non-professionally trained."

Devlin qualified this by saying he is not suggesting a free rein by given to all addiction workers, but rather that efforts be made to define the characteristics and necessary training required by lay individuals in the drug rehabilitation field.

His further suggestions were:

- to explore the limits of competence that non-professionally trained therapists have attained;
- to describe the work environment in which such individuals function most adequately;
- to set up governing body that will train, examine, and license such individuals, at the same time recognizing the needs of society and protecting it against the unqualified therapist.

The Portage Program (Suite 1507, 360 St. James St. W., Montreal) through research hopes to give direction and impetus to these goals.

Judges and addicts trade experiences

By DAVID ZIMMERMAN

NEW YORK—The City's Addiction Services Administration (ASA) recently sponsored an unusual social reception: It brought together judges of the criminal courts, and addicts whom the judges had diverted to treatment programs at the behest of ASA's innovative three-year-old Court Referral Project (CRP).

One 32-year-old, admitted ex-burglar, ex-dealer and ex-addict, gratified the judge who gave him his break—as well as ASA officials and news reporters present—when he said:

"It saved my life!"

Replied the judge:

"Thanks for telling me that. It makes me feel very good!"

Under the program, CRP client Richard LaManna spent 18 months in a therapeutic community, then went through re-entry, and is now living on his own. He works for an executive recruitment company and says he is through with drugs and crime.

CRP officials consider LaManna an outstanding success. By their official—and more modest—measuring stick, one year retention in treatment, some 40% of their referrals are successes, according to ASA Commissioner Jerome Hornblass.

The CRP staff currently interviews some 6,000 arrested addicts each year before trial. Most are charged with misdemeanors, although about one in four is a felony arrest. Excluded from consideration are individuals charged with homicide, serious robbery or assault, residential burglary or sex crimes.

CRP interviewers, many of them ex-addicts, are instructed to rely heavily on their "vibes" in deciding whether a prisoner is a good candidate for referral. They recommend against referral for individuals who lie to them or seem to lack motivation. Others, for whom they make referral recommendations, end up not being referred because of the legal exigencies of their particular cases.

Roughly half of the 6,000 individuals interviewed are referred, and the one-year retention figure is 40% of these 3,000 persons.

The CRP program, with between 50 and 60 employees, costs $900,000 per year. Thus, the cost per person interviewed is roughly $150, the cost per referral is roughly $300. The project was founded with a Federal grant, but is deemed successful by New York City, and henceforth will be municipally funded.

The project's founder and first director, lawyer Martin Mayer, 33, is now director of all ASA criminal justice projects. He said recently in an interview, "we've done incredibly well" in establishing a credible, centralized and accountable referral system within the court structure. The project thus has successfully fulfilled one of two initial goals.

The second goal was to provide rational matching between individuals and treatment programs. Mayer said:

"We were hoping that by making a match, we'd have retention rates two or three times higher than the retention rate for self referrals from the street—and it hasn't been that way."

This failure, Mayer said, raises the quesion of whether coercive referral programs provide better results than voluntary ones: Several problems frustrate definitive judgment.

In New York City, he said, there is coercion to get into treatment, and so to avoid trial and possible conviction, but much less coercion against splitting, once the referral has been made and the case adjourned.

The reason, Mayer said, is that the bench warrants issued for splittees are virtually never served because the city's warrant squad of 30 policement faces a backlog of more than 100,000 warrants.

In New Jersey, Mayer said, where a significant number of bench warrants is acted on, retention rate of court referrals is much higher.

He said CRP's clout is mitigated by the fact the maximum sentence for a misdemeanor is one year. Most addict criminals do this light time with ease, he said. Moreover, if they split and are re-arrested for another offence, the two charges are usually combined and the parole violation for having split, usually ignored. Thus, the penalty for splitting after referral is relatively modest.

Mayer said he personally does not favor an effort to improve the retention rate by enhancing the program's legal clout. In New York City, unlike other jurisdictions, an individual does not need to plead guilty in order to be referred for treatment, he said.

When it was started, CRP was one of the first referral projects for addict criminals. Now, dozens have sprung up, confirming the New York experience that the concept is a viable one.

One thing that Mayer has learned, he said, is there seems to be an advantage in having a lawyer, rather than a social worker or other rehabilitation professional at the head of a court referral program. The reason is that lawyers are accepted as members of their "clique" by DAs and judges, and so are accorded greater credence.

"The idea of diversion," Mayer said, "is good, because it's something to try that's different from simply locking a guy up, which we know doesn't work."

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

Postgraduate Day on Clinical Pharmacology—Antimicrobial Drugs—April 5, Toronto, Ont. Information: The Director, Division of Postgraduate Medical Education, Faculty of Medicine, Medical Sciences Building, University of Toronto, Toronto, Ont. M5S 1A8.

National Drug Abuse Conference—April 4-7, New Orleans. Information: Mr. V. Shorty Director, Desire Narcotic Rehabilitation Center, 3307 Desire Parkway, New Orleans, Louisiana 70126.

59th Annual Meeting of the Federation of American Societies for Experimental Biology—April 13-18, Atlantic City, New Jersey. Information: Mrs. T. C. Heatwole, Director, Public Information, 5110 W. Franklin St., Richmond, Virginia 23226.

The John Marshall Law School and the Drug Abuse Council, Incorporated, present a Comparative Law Symposium on the Social Control of Drugs—April 18-19, Chicago, Ill. Registration fee $35. Information: R. W. Olson, Assistant Dean, The John Marshall Law School, 315 South Plymouth Court, Chicago, Ill. 60604.

First International Congress on Patient Counselling—April 21-23, 1976, Amsterdam. Information: Congress Secretariat, First International Congress on Patient Counselling, c/o Excerpta Medica Foundation, P.O. Box 1126, Amsterdam, The Netherlands.

National Alcoholism Forum—Annual Conference of the National Council on Alcoholism—April 27-May 2, Milwaukee, Wisconsin. Information: George C. Dimas, Executive Director, National Council on Alcoholism, 2 Park Avenue, N.Y. 10016.

Sixth Annual Medical Scientific Conference of the National Council on Alcoholism—April 28-29, Milwaukee, Wisconsin. Information: George C. Dimas, Executive Director, National Council on Alcoholism, 2 Park Avenue, N.Y. 10016.

Annual Meeting of the American Psychiatric Association—May 5-9, Anaheim, Calif. Information: Dr. W. E. Barton, Medical Director, 1700 18th Street, N.W., Washington, D.C. 20009.

First International Conference on Substance Abuse in Industry—May 6-9, Detroit, Michigan. Information: Special Programs Department, Society of Manufacturing Engineers, 20501 Ford Road, Dearborn, Michigan 48128.

37th Annual Scientific Meeting, The Committee on Problems of Drug Dependence—May 19-21, Washington D.C. Information: Executive Secretary, Committee on Problems of Drug Dependence, NAS-NRC, 2101 Constitution Ave., N.W., Washington D.C. 20418.

Institute on Crime, Justice and Heroin—May 19-June 3, London, England. Information: Dr. A. S. Trebach, Centre for the Administration of Justice, The American University, Washington, D.C. 20016.

Physical Illness and Family Therapy—May 30-31, Toronto, Ont. Information: The Director, Division of Postgraduate Medical Education, University of Toronto, Toronto, Ont., M5S 1A8.

10th Annual Conference of the Association of Halfway House Alcoholism Programs of North America, Incorporated—June 8-11, Hot Springs, Arkansas. Information: Jack Shea, Conference Coordinator, Association Office, 786 E. Seventh St., St. Paul, Minnesota 55106.

New England School of Alcohol Studies—June 8-13, University of Vermont, Burlington, VT. Information: Jan S. Durand, Coordinator, P.O. Box 11009, Newington, CT 06111.

21st International Institute on the Prevention and Treatment of Alcoholism—June 9-15, Helsinki, Finland. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

American Medical Association Meeting—June 14-19, Atlantic City, N.J. Information: Dr. J. H. Sammons, Executive Vice-President, 535 N. Dearborn Street, Chicago, Illinois 60610.

Joint Meeting of the Canadian Medical Association and the Alberta Medical Association—June 22-27, Calgary, Alberta. Information: Ms. H. Otto, CMA, Box 8650, Ottawa, Ont. K1G 0G8.

Rutgers Summer School of Alcohol Studies—June 22-July 11, New Brunswick, N.J. Application deadline May 1. Information: Miss L. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

Positions Available

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The Sonoma County Community Mental Health Alcoholism program is looking for an experienced person to supervise their clinical staff. The requirements are a Master's Degree in Social Work, Psychology, Rehab. Counseling or related field plus three years post-graduate experience, with at least one year in an alcoholism program.

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2555 Mendocino Avenue
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An in-depth report

Codeine crisis: Does one exist?

By DAVID ZIMMERMAN

WASHINGTON D.C.—There is violent tugging and shoving at that improbable nexus which ties drug abuse control to the legitimate use of pain-killing opiate derivatives. That nexus is the cultivation of the opium poppy (*Papaver somniferum*).

Important technical developments and policy shifts are in progress here. They call to mind the warning by Ed Brecher, in his book, *Licit & Illicit Drugs*, that each policy shift in the attempt to control drug abuse invariably creates a new, and often more difficult problem. The *zag*, Brecher seems to say, always is worse than the preceding *zig*—and this well may be what is happening to the opium trade.

There is wide agreement among experts that there is a worldwide squeeze on supplies of raw opium for medicinal uses. The severity of the problem, who caused it, and what is to be done to refill licit supply lines, without swelling illicit ones—are unresolved and controversial questions.

Organized medicine, with considerable assistance and encouragement from the Washington lobbyist for the three U.S. processors of crude opium, has orchestrated a scare campaign that has been accepted by the press, and purveyed to the public at face value.

"No opium for pain—a threatening medical crisis," exclaimed the usually staid and highly respected *New England Journal of Medicine* last December 26, in headlining an editorial which charged that "this critical shortage of codeine, morphine, and medicinal opiate drugs . . . could easily cause great suffering, with the American public being deprived of its right to these important medicines for relief of pain." Added editorialist Dr. Leonard Greentree, an obstetrician from Columbus, Ohio:

"As the matter stands today, the spectre of no opium for pain in the U.S. is well founded."

The American Medical Association, in calling a "top-level conference" for Washington, D.C. in March to "attack the problem of an iminent critical shortage of medicinal opium," quoted one of its officials, Dr. William Barclay, as saying:

"Medical practitioners may soon be faced with a shortage or unavailability of a drug that has long been a mainstay in relieving pain and controlling coughs."

A similar doomsday message was carried to Congress by the lobbyist for the opium processors, Mrs. Jane McGrew, an intense, dynamic, persuasive attorney who works for the Washington law firm of Steptoe & Johnson.

The "current shortage of licit opium," she said, "threatens the adequacy of our domestic supply of opium derivatives".

Mrs. McGrew represents Mallinckrodt, Inc., of St. Louis; Merck & Co., Inc., of Rahway, N.J.; and S. B. Penick & Co., of New York, the only three companies licensed by the federal government to import crude opium. They process the opium gum into morphine and codeine, which they sell to four large companies, and five dozen smaller ones—called "formulators"—that use it to make pain-killers (analgesics), and cough medication (antitussives).

A number of important drugs are involved, including morphine, codeine and paregoric, which is used to control diarrhea, and the narcotics antagonists naloxone and nalorphine. So shortages, if they materialized, would be cause for alarm. The industry figures also show, however, that codeine accounts for 95% of the processors' sales. *All* other licit opiate drugs come from the remaining 5% of imported opium.

So, barring a total disruption of supplies—which no one foresees—the crisis, if it exists, is essentially a crisis in the supply of codeine.

Codeine is one of the medical stand-bys, a familiar, effective, widely-used drug.

A major advantage is that it is effective as an analgesic when given by mouth. Another is that it has a low, although quite real, potential for abuse. A common, and troublesome, side effect is constipation.

Codeine is regarded by pharmacologists as a "mild" analgesic,

and frequently is used to relieve mild to moderate pain. A leading analgesic investigator, Dr. William T. Beaver of Georgetown University here, has said that a standard dose (60 mg.) of codeine is the approximate pain-killing equivalent of two tablets (600 mg.) of aspirin.

But, he adds, since the two analgesics act in different ways, they beneficially may be combined. In fact, much codeine is sold in combinations, e.g. *Empirin compound with codeine*.

Dr. Beaver, chosen by AMA to assess codeine's medicinal value at the Washington conference, says codeine is an important—and in some cases irreplaceable—drug. But, he conceded in an interview, there are other pains against which a non-narcotic analgesic—aspirin or acetametaphin to name two—would be as effective.

"There is no evidence," he added, "that using 65 mg. codeine is better than 2 aspirin or 2 tablets (600 mg.) acetametaphin."

Dr. Beaver said:

"There is a legitimate demand for codeine. But it's not like penicillin. No one is dying for lack of codeine—or is going to."

Besides aspirin-like analgesics, there are several stronger synthetic analgesics that are used to control moderate to severe pain; they include *Darvon* and *Talwin*.

Experts differ on whether, and in what percentage of cases, these drugs are equal substitutes, or adequate ones, for codeine.

Based in part on Dr. Beaver's work, the well-regarded drug-rating publication, the *Medical Letter*, in a forthcoming *Medical Letter Reference Handbook*, says that for moderate pain, "codeine is the oral analgesic of choice when a non-narcotic analgesic such as aspirin is contraindicted or ineffective."

Given these rather circumscribed indications, the number of codeine prescriptions written each year, according to industry figures, may come as a surprise. In 1972, more than 30 million prescriptions for codeine pain-killers were filled in U.S. pharmacies. The number of people treated with codeine in hospitals is unknown, but the bulk codeine purchased by hospitals is 50% greater than the amount sold on prescription through pharmacies.

The other use of codeine, besides analgesia, is as an antitussive. This is a diminishing share of the codeine market—Mrs. McGrew calculates that 20% of codeine is formulated into cough preparations—but still accounts for 24 million prescriptions for codeine cough medications each year. In addition, there is codeine in uncounted over-the-counter (OTC) cough remedies, which may be legally sold in many states.

The *Medical Letter* (2/5/71) says that "coughs frequently . . . are self-limited, of brief duration, and do not require an arsenal of drugs for relief," and suggests that much cough medication, particularly combination remedies—in which codeine often is used—are unnecessary.

It says codeine and other effective drugs often are present in cough remedies in suboptimal, "ineffectual" amounts—which means that these drugs are wasted.

The industry figures suggest that more than 100,000,000 prescription or OTC codeine courses of treatment are used in the U.S. each year.

Codeine use is rapidly rising. Ambassador Sheldon Vance, the State Department narcotics specialist, told the AMA meeting that bulk codeine sales rose 73% in the U.S. between 1967 and 1973.

An industry projection, prepared by Mrs. McGrew on the basis of sales, forecasts a doubling of codeine sales, from 29,000 kilos per year in 1972, to 62,500 kilos per year by 1978.

Ambassador Vance and others at the conference cited this rising demand as a principal cause of the current codeine shortage. While U.S. demand has gone up, he said, codeine use has declined 25% in the USSR in the last five years. It has remained constant in Britain. Mr. Vance pointed out that the U.S. now is the world's major codeine consumer, although it is not the leader in per capita use.

The industry equates the increasing sales with an older, "achier" population receiving increasingly better medical care through Medicare, Medicaid and other health delivery systems.

Mrs. McGrew conceded that the industry projections are "based on sales, based on medical demand," not on any direct assessment of clinical need.

An HEW official, Dr. John Jennings, said his agency "takes the position" that the need "overall" is "valid". He said, in an interview, that "we saw nowhere we could see any way of reducing the use of codeine."

The one possible exception, he said, was in OTC anti-tussives. He indicated he would prefer to see the codeine content raised to optimal levels in these products, rather than eliminate the products in those states where they continue to be legal.

No one at the AMA meeting offered any evidence to document a rising clinical need for codeine. The question of whether this alleged need was being stimulated by pharmaceutical advertising was raised from the floor, but unanswered, for want of data.

One who expressed scepticism at the need—and concern for the consequences—of great public concern about codeine supplies was Sir Harry Greenfield, director emeritus of the International Narcotics Control Board.

Noting that no other countries have "so far evinced any marked degree of anxiety" about codeine supplies. Sir Harry said the matter demanded "careful, scrupulously objective" investigation, "without preconception".

While Sir Harry, Ambassador Vance, and others, see rising U.S. demand as a major cause for tight codeine supplies, industry and medical representatives whip the government.

Thus, Charles Morton, general manager of the pharmaceutical division of the A. H. Robins Company, one of the major formulators of codeine products, of Richmond, Va., told The Journal recently that the "State Department has been the biggest culprit" in causing the shortage. Principally, Morton and others refer to the State Department's initially successful attempt to halt poppy culture in Turkey.

This is a popular stance, at a time when the Nixon Administration is a convenient whipping boy. But Dr. Robert DuPont, the current SAODAP chief, reiterated that "the (now rescinded) ban in Turkey seemed to be correlated with a very significant decrease in illicit heroin in the U.S., especially in the East."

Dr. DuPont saw a "consensus" in which, "beyond any question—and this is the government position now—opium drugs have a role in legitimate medical practice, and government has a responsibility to assist in providing necessary opium for good medical practice.

"It is also obvious that control

of these substances is of extreme importance."

Narcotics control officials at the meeting conceded they spoke in part on the basis of fact, and in part too, to discourage scare talk about codeine shortages, that predictably would lead to increased production.

As conspicuously absent as the question of whether some codeine uses were more essential than others, was a question of whether, and if so how, it might be rationed by processors, formulators, organized medicine or the government.

Opium processors' lobbyist, Mrs. McGrew, backed by officials of the three companies she represents, heatedly rejected—as illegal, unwise, unethical and impossible—any allocations plan.

While insisting there is a "serious crisis," Mrs. McGrew insisted too that "it is the wrong thing for our group to do to say we'll wipe out 20% of the uses because there's no use for it.

"I see no evidence of misuse with regard to prescription use of narcotics."

"We learned a long time ago," Ambassador Vance said, "that the result of having excessive quantities of opium is that much of it ends up as heroin for distribution in the U.S."

This cachet notwithstanding, Ambassador Vance, Dr. DuPont, and attorney Donald Miller—chief counsel for the Drug Enforcement Administration (DEA)—insisted there was not—and need not be—a codeine shortage in the U.S., provided U.S. processers bid aggressively for poppy straw in Turkey and other countries when it comes on the market in the next several months.

"There has not been a shortage," Vance said, and "I do not foresee a situation where patients in the U.S. will be denied medicinal narcotics because of supply shortages."

Given that the AMA meeting was convened to deal with an alleged critical shortage of codeine, some participants found it curious that speakers from AMA and the medical community failed to address themselves to the problem of what percent of codeine uses, if any, could be dispensed with, were a shortage to develop.

Neither was there a report on ways that codeine might be allocated to possibly more essential uses, instead of possibly less essential ones, if the supply squeeze—which is projected to be most severe this autumn—should materialize.

Rather, reports by Dr. Beaver, and AMA researcher Chris Theodore on doctor's prescribing habits, dealt with whether doctors could, or would like to, do without codeine and other opiates altogether—a moot point.

The research director of Bristol Laboratories, Dr. Irwin Pachtor, stood to say:

"The speakers all spoke of an all or nothing phenomenon. I'd like to hear someone talk about what if we had a shortfall—say of 30%?"

Replied AMA statistical expert Mr. Theodore: "It would be important to find out how physicians would feel about this 'grey area'." But, he said, the sampling methods available to him were not sophisticated enough to yield such answers.

As the AMA's Washington conference ended, Dr. Barclay conceded that the crisis he had called it to meet might not exist.

"We'll probably get through 1975 without any patient needing to return to his doctor to get a new prescription because the codeine one was not fillable," he said.

No steps were taken to prepare for rationing or allocation of supplies, at any level, should a shortage in fact develop, or to provide doctors with guidelines as to which of codeine's several uses might, in a pinch, be replaced by synthetics like *Demerol*, *Darvon*, or *Talwan*—or by aspirin.

Endorsements were offered, in the name of legitimate analgesic need, to two actions that control experts warned could create new problems of illicit diversion: One is the increasing cultivation of opium poppy abroad. The other is a start to *Papaver bracteatum* culture in the U.S.

Was a forceful new *zag* in opium policy about to give rise to new problems, more acute even than the *zig* that brought it about? One could not help but wonder.

The Journal

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INCEST

'A causative factor'

By ANNE MACLENNAN

NEW ORLEANS—Almost half of all the female inpatients of 44 therapeutic communities in the United States had incestuous relationships before they were 15 years old.

In 75% of the cases, the assaults took place before the children were 12 years old and in 45% of the cases, before they were aged nine.

Partners included not only fathers but stepfathers, grandfathers, uncles, and quasi-family members such as the mother's current sexual partner.

More than 90% of the women had never before admitted to having had such a relationship.

Judianne Densen-Gerber

These are among the chief findings of a survey in early December, 1974, of 118 female residents of Odyssey House, Inc. units throughout the US. Forty-four per cent reported childhood incestuous relationships.

It is the highest figure ever reported in any of the albeit few studies of incest. And it stands in stark contrast to the highest previously reported figure of 4% revealed in a survey of an unselected population of 650 women psychiatric patients in Northern Ireland.

The American study is titled Incest as a Causative Factor in Anti-Social Behavior and subtitled *The Unspeakable Sin of* the Father Which Must Rest Upon The Child. It was reported here at the National Drug Abuse Conference by Dr. Judianne Densen-Gerber, psychiatrist, lawyer, and head of Odyssey House, Inc.

She termed the findings "devastating" and said the facts in the individual cases were "horrendous".

"People say well what do you expect in a drug addict, antisocial, criminal alcoholic population?

"My immediate response to them is, were they this population when they were three, four, five, six years of age? And I ask people to think what happens to a little girl if, in order to be fed, she has to perform fellatio on her father when she is four.

"Does she have a sense of control over her own body? Does she have a sense of self? Does she have a sense of self that she can go ahead in the world and accomplish things?

"I think what we're talking about here is the right of a child to have a say over the body, the right of a child not to be in an authority set in which that child has no controls. And if you start at three, four and five with a child saying she has no way to protect her body from sexual exploration, then how is she going to grow up and believe that she can cope?"

The survey was in the form of a questionnaire administered, on the same day by senior women staff members of each unit, in

(See—Incest—page 4)

Significant changes expected as cannabis hearings close

OTTAWA—With the novelty of televised committee hearings already fading like old make-up, the Senate committee on legal and constitutional affairs is wrapping up its consideration of the federal government's long-awaited bill to change cannabis laws in Canada.

For the next few weeks, the Senators will be meeting behind closed doors to consider the results of their mini-LeDain Commission inquiry into the pros and cons of easing penalties for most cannabis offences, as the proposed legislation would do, and into the legal loopholes and other problems contained in the bill.

On the basis of the public hearings, it seems certain the Committee will recommend a number of significant amendments to the Bill.

There is even the possibility, though not the probability, that it might try to change the bill to replace the proposed milder criminal sanctions for cannabis possession with civil sanctions, to remove what many witnesses suggest is the unacceptable stigma of a criminal record.

But since the Bill has yet to go through final reading in the Senate and then survive the full course in the Commons, it will be months before the cannabis legislation is finally approved, whatever the form.

There have been some interesting highlights in the final weeks of hearings, beyond the flurry of interest in television cameras.

Dr. Ian Henderson, a University of Ottawa pharmacologist, remarked informally at one session that the proposed legislation would have to be flexible enough to allow the expected use of marijuana as a medicine for treating eye problems.

In an interview Dr. Henderson's said marijuana might become a useful drug again, after a 40-year retirement—this time in the treatment of glaucoma.

He suggested that in a year or two, doctors will be using cannabinol drops to lower the pressure inside the eyes of glaucoma victims, thereby preventing blindness.

He also said that cannabis may prove useful in combatting the nausea resulting from anti-cancer radiation therapy, while at the same time stimulating the patient's appetite.There is even the suggestion it might work in treating asthma.

More on Senate hearings—pg 2

One problem, however, is that patients tend to develop tolerance to the drug and larger and larger doses must be used.

Originally, many years ago, marijuana was used as a painkiller.

Meanwhile, two workers from the Durham office of the Addiction Research Foundation of Ontario called for elimination of criminal records for people convicted of marijuana possession.

Wayne Weagle, director of the Durham region ARF in Oshawa, said he feels some of the greatest damage from cannabis is that inflicted by the laws designed to control its use.

The trauma of confrontation with police, parents and the courts and then receiving a criminal record, may be too much for a young cannabis offender who may already be facing identity problems.

Another group, including a number of ARF scientists, told the Senate committee that recent ARF studies indicate that many more cannabis users are now driving while under the influence of cannabis than a few years ago.

Recent studies indicate that 50% of regular users admitted in interviews that they have driven while under the influence of cannabis.

The concern is that traffic accidents will increase as a result of cannabis impairment, as now happens with alcohol.

The same scientists suggested the proposed jail sentences for first offenders of cannabis possession who cannot pay their fines seem, on the surface at least, to discriminate against the poor, unless fines were made proportional to the income of the individual involved.

NEW LOOK

WE'RE CHANGING—with this issue of The Journal.

New features include:- "Backgrounder" to the news, and "Guest Book" (page 9) which will allow invited readers to share current thoughts. Wayne Howell's column, a regular feature for three years, moves to a new spot.

"The Back Page" is designed to facilitate readership of in-depth reports by The Journal's team of international correspondents.

And, as you see, we have moved out of the "Black and White" era.

Safe smoking for some ?

TORONTO—There may be good news in the offing for cigarette smokers. But first, a medical research team here needs twins—especially identical twins who smoke.

The good news may prove to be that as far as emphysema and bronchitis are concerned, some smokers may be safe. Others may inherit the capacity to develop such diseases.

The team, headed by Dr. Colin Woolf, a professor of medicine at University of Toronto, has been studying smokers and their lungs for 10 years.

In one study of about 100 women, results after five years were not surprising. The more the women smoked, the greater the degree of cough, phlegm, shortness of breath, wheezing, and whistling noises in the chest. Breathing tests in smokers were generally poorer, and non-smokers inhaled and exhaled air more easily than smokers.

Statistically, test results of women who had never smoked and those who were ex-smokers were indistinguishable.

In further study, however, researchers found that many of the women, even heavy smokers, had *no symptoms at all.*

They divided this group without symptoms into light smokers (fewer than 10 cigarettes a day); moderate (10 to 20 a day); and heavy (more than 20 a day).

Their breathing test results were indistinguishable from those of women who had never smoked.

There are certain indications that people who smoke heavily may well have a disease in spite of feeling well and lacking symptoms. And they may be damaging their lungs, cautioned Dr. Woolf who is also director of the Trihospital Respiratory Service (Toronto General, Mount Sinai and Women's College Hospitals.

However, while smokers are at risk, symptoms or not, he said, people who smoke less than 20 cigarettes a day, if they have no

(See—Smoking—Page 4)

SAODAP prepares to die

By DAVID ZIMMERMAN

WASHINGTON—The Special Action Office for Drug Abuse Prevention (SAODAP) will cease to exist on June 30, barring a last unforseen effort by Congress to prolong its existence.

In its four years of life, SAODAP has led and coordinated the federal effort to control, treat, and prevent drug abuse in the U.S. While many leaders in the drug rehabilitation community feel the job is not yet complete—and some have asked that SAODAP be continued—it was originally conceived as a temporary activity and its termination was forseen from the outset.

The effect of its disappearance on drug rehabilitation efforts is "kind of hard to assess," according to Richard Bucher, executive assistant to the director of SAODAP.

"I fear an unintended message might be given to the drug abuse prevention community that there is considerably less emphasis going to be given (to drug abuse) at the federal level. I hope the message won't be received too strongly, and that a careful look will show that the federal priorities on drug abuse prevention still remain rather high."

As proof, Mr. Bucher pointed to the fact that the administration's budget request for fiscal 1976 for the National Institute on Drug Abuse—which, like SAODAP, is directed by Washington, D.C. psychiatrist Dr. Robert Dupont—is so much higher than the figure appropriated for fiscal year 1975.

The raise, he said, comes at a time when most community service appropriations are being drastically cut.

The SAODAP budget for the current year was $18 million. A "fair amount" of NIDA's raise comes from money that this year went to SAODAP, Bucher said.

In terms of administrative efficacy in cordinating drug abuse prevention and treatment activities, Mr. Bucher was less sanguine. He said there were eight federal agencies—as disparate as the department of defence; the department of health, education and welfare; and the labor department—with major drug abuse programs, and a dozen other agencies with minor problems.

Coordination of these efforts has been a major SAODAP achievement, he said, and SAODAP's disappearance will complicate interagency agreement and executive approval of drug policy and program.

Compared to SAODAP, Bucher said, NIDA is in "a much more difficult position—four layers into the HEW bureaucracy", in terms of competing for dollars and basic

(See—SAODAP—page 3)

Ontario campaign page 5

... INSIDE

Trial period would facilitate research

A 5-year cannabis experiment

By BRYNE CARRUTHERS

OTTAWA—Any changes in Canada's cannabis laws should be enacted for a trial five or 10-year period, so the before and after effects of such changes could be adequately measured.

With the appropriate detailed scientific surveys of the effects of cannabis use, and of the impact of the application of the law before, during, and after such trial changes in cannabis laws, Canadians could then be in the unusual situation of making more definitive decisions about what to do with cannabis and the law on the basis "not merely of a restatement of the original ideologies, fears or conjectures . . . but on the basis of a new and larger body of evidence."

The suggestion was made to the Senate legal and constitutional affairs committee, which is completing its consideration of the Government's proposed cannabis legislation. It was contained in a brief prepared by Drs. Harold and Oriana Kalant, of the Addiction Research Foundation of Ontario, at the invitation of the Senate Committee. The brief was co-signed by a number of scientists at ARF and the Department of Pharmacology, University of Toronto.

Dr. Kalant made it clear he and his fellow scientists were expressing personal views and not the official views of their organizations.

Perhaps as a direct result of this non-agency approach, the resulting brief to the Senate committee seemed on first and subsequent glances to be both the most informative and the most scientifically sound brief yet to be dealt with by the Committee.

[illegible] ble experience in researching the effects of alcohol on the human condition, drew a parallel throughout the presentation between alcohol and cannabis as drugs.

"We know of no evidence, really, that cannabis is inherently more dangerous than alcohol if used in the equivalent amounts by the same numbers of people for the same length of time and under the same social circumstances.

"Neither do we wish to argue that there is inherently any greater justice in restricting the use of cannabis than in restricting the use of alcohol.

"But there is ample evidence that combined use of both means greater total drug use and greater likelihood of heavy damaging use.

"And this is the problem really that legislators have to deal with.

"In other words, when one legislates a change in the law on cannabis, one is not only legislating a change in the law on cannabis but a possible change in the total amount of drug use, including alcohol, cannabis and other drugs as well."

Elsewhere, the brief argued that the retention of civil penalties for possession of cannabis (as opposed to criminal penalties and the accompanying criminal record) and the continued illegality of sale or cultivation of cannabis "can permit legal controls to exert a significant deterrent effect".

As an example of the hypothesis that it is not necessary to have criminal sanctions to produce an effective deterrent, the Kalant brief pointed to the drinking situation before and after the legal drinking age in most provinces was dropped to 18 years from 21.

Even though everyone had assumed alcohol before the change was being widely used illegally by under-age drinkers, Dr. Kalant noted that when the change did take place, there was a large, almost immediate jump in alcohol consumption by the 18-to 21-year-old group.

"This demonstrates both that the legal restrictions had in fact a deterrent effect, even though they did not involve criminal charges, and that outright legislation did lead to a large increase in what was already widely practiced behavior."

In another parallel, Dr. Kalant and his associates argued that prohibition in the U.S. did in fact result in lower alcohol consumption, in spite of the commonly held belief that it failed to accomplish its purpose.

Similarly, the scientists wondered how much more cannabis use would increase, in the absence of legal penalties which some suggest have failed to stop the use of cannabis.

In another parallel based on experience with alcohol use, and the even more dramatic increase in health related effects, the scientists predicted that as the total level use of alcohol and of cannabis in the population goes up, there will be a disproportionately large increase in the incidence of health and social problems related to heavy use in the case of each drug, even though there might only be a relatively small increase in the total number of users of each drug.

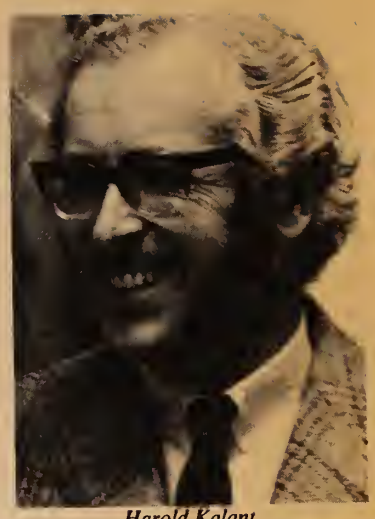
The brief took a broad swipe at both extremes in the cannabis public and scientific debate, suggesting that both sides too often forget, or refuse, to put things into proper perspective.

In the case of those citing the evils of cannabis, oftentimes the vital "ifs" and parameters of the original experiments are forgotten—for example, the fact that oftentimes a large amount of a drug must be used to produce a particular harmful effect, thereby indicating only the possibility of a problem in a smaller percentage of users at lower doses.

Another fact often ignored is that many, if not most, of the harmful effects from high or long-term intakes of cannabis can and do also result with the heavy or long-term use of other drugs—such as alcohol.

On the other side of the coin, Kalant noted that some widely-publicized studies purporting to show a lack of harmful effects from cannabis use are often too small in terms of sample size to prove anything, or too limited in approach to prove much.

As an example, he noted that recent reports of studies using populations in Jamaica and Greece suggested there had been no evidence uncovered of intellectual or mental impairment—a hazard uncovered in animal tests that has also been noted with long-term use of other drugs, such as alcohol.



Harold Kalant

The studies involved only 10 to 40 persons per group, "which is far too little to detect a complication that may effect only a few percent of users.

"If we use alcohol—and we have a much better knowledge of alcohol—as a guide, we know that only a few percent of heavy users will get brain injury, so that we can conjecture that perhaps 5% or so of chronic heavy users of cannabis might also develop it.

"If you have a group of 10 users, that would mean that perhaps one-half of one user might show signs of brain damage."

Another problem with the studies is that the subjects were poor, subsistence level workers, fishermen, and day laborers, whose activities involved minimal intellectual demand and whose measured intelligence levels were significantly below the general level.

"If you are looking for subtle changes in intellectual performance, memory, learning ability, and the like, how are you going to find it in a group whose whole life pattern makes least demand on *the very things that* we are attempting to measure?"

Dr. Kalant warned that Parliament cannot defer a decision in the expectation that all relevant information will be available eventually.

"There will never be a time when all of the relevant information will be available, because the gathering of information of a scientific basis is an endless process."

"Therefore, Parliaments, like individuals, find themselves from time to time in the position of having to make decisions under a given set of circumstances in the light of existing realities, even though they may have less information available than they might like to have."

The idea of implementing changes for a trial five or 10-year period, and doing research before, during and after the change to see the various effects, would seem to offer an opportunity for Parliamentarians to have better facts at their finger tips the next time a decision must be made.

Surprise findings in Oregon

OTTAWA—Oregon, the only state in the union to decriminalize the crime of possessing marijuana, albeit one ounce or less, seems to be finding that citizens are using less of the drug, not more as might be expected.

Patrick Horton, a district attorney in Eugene, Oregon, who ran for office on a "decriminalize marijuana platform," told the Senate legal and constitutional affairs committee that a number of other "refreshing things" have been happening since Oregon in effect made possession of an ounce or less of cannabis a civil offence.

"We are now able to concentrate on areas which we feel are of more social value, of more commitment to the people—heroin, amphetamines, barbituates and the like."

In addition, one-third of the state's criminal trial dockets which used to be composed of marijuana cases can now be used for other, more important cases.

"The jails are filled with the true criminal now, rather than the youthful drug offender who, because of his status in the community, is either a laborer or a student and many times is unable to post the necessary security to gain his release pre-trial," Mr. Horton told the Senate Committee.

Under the state's changed laws, people found with small amounts of marijuana are issued a citation, much like a ticket for a traffic violation, that requires appearance in court instead of compulsory detention in jail.

Mr. Norton claimed his officials followed a number of tagged marijuana possession offenders through the courts after the ticketing. All of them appeared in court, contrary to fears from some quarters that some offenders might try to skip trial. Most pleaded guilty.

Mr. Norton also claims "the rapport between the community and the police is good and has improved substantially" since the legal changes.

But the Senators also brought out some problems with Oregon's experiment.

Hashish, a concentrated version of marijuana, has been excluded from the decriminalization, in part because the state legislators decided that an ounce of hashish was more potent than an ounce of marijuana or 15 to 20 marijuana cigarettes.

Even though the individual found guilty of possession of an ounce or less of marijuana does not have a criminal record, the fact that he has been brought to court is recorded on the FBI "rap" sheet and might come back to haunt the individual.

In Oregon, the fine can be $100, though Mr. Horton claims the average fine is more like $25 to $35.

The change in legal standing of marijuana in Oregon has also had its effects on the illicit market.

Mr. Horton said that now typical "baggies" of marijuana are only an ounce, compared to 1.5 to 2 ounces before the change, suggesting that less marijuana is being sold at one time.

He said there has been no public flaunting of the law with open smoking of pot in the streets, theatres and public places.

"That is one of the most refreshing things about it. We found that the citizenry responded with a great deal of good faith."

Asked why Oregon was the first and remains the only state to decriminalize marijuana, Mr. Horton said its population is young, relatively small, and from many other parts of the country.

"We just do not have many of the traditional things to overcome that other states do have," he said, adding that was a personal view.

He said a number of other states, including California, Colorado, Hawaii, Tennessee, Texas, New York and the federal government, are either considering or discussing decriminalization of marijuana.

'Alcoholism as a defence' - effort stalemated

WASHINGTON DC—Efforts of the National Advisory Council on Alcohol Abuse and Alcoholism to have the Criminal Code revised to consider alcoholism in the same light as mental illness as a defence, appear to be stalemated.

The council recommended in September 1974, that the "Federal Criminal Code should explicitly provide that alcoholism is a defence to prosecution under the Federal law, to the same exent and under the same conditions as any other illness considered in the Code. Such legislation would substitute appropriate treatment and rehabilitation under civil law, instead of punishment under criminal law."

The Resolution concluded an appeal to the Secretary of the Department of Health Education and Welfare (HEW), Caspar Weinberger, to support the measure.

Dr Morris Chafetz, director of the National Institute on Alcohol Abuse and Alcoholism, approached Secretary Weinberger and requested his support. To date, however, nothing has happened.

Meanwhile, hearings before the Senate Judiciary Subcommittee on Criminal Laws continue, and a lobbyist from the American Civil Liberties Union said his organization (which supports the decriminalization of "all victimless crimes") has made no progress. He surmised legislation would probably come about on a state level before it was incorporated into the Federal Criminal Code.

The ACLU is only attempting to have marijuana use decriminalized federally at present.

As far as alcoholism is concerned, Jay Miller of the ACLU pointed out that taking alcohol was not criminal in the USA and as far as having alcoholism treated as an illness was concerned, he said "We're not into that at all."

Drug-carrying donkeys cross borders

GENEVA—Frontier guards from various nations are apparently reporting that animals are being used by drug smugglers.

A UN agency here has been told that in Argentina, donkeys have been trained to amble across borders carrying bags of coca leaves.

Similarly, Iran has reported the exploitation of innocent-looking sheep, with opium hidden beneath their wool. Again, the animals freely cross national frontiers.

A spokesman for Pharma Information (representing the Swiss pharmaceutical firms Ciba-Geigy, Roche and Sandoz) said other ruses for smuggling drugs included disguising the characteristic odours by sprinkling consignments with garlic or transporting the illicit material in cartons of onions.

"Petrol may be splashed around the cargo. Quite commonly also, traffickers wrap the very malodorous brown opium in plastic and encase it in plaster of paris," the spokesman said.

Other unusual hiding places have included reading material for blind persons, snail shells, one egg in a carton of eggs, double-bottomed wine bottles, artificial flowers, and a wooden cage containing a live animal.

Nixon's motives aside SAODAP did achieve

By DAVID ZIMMERMAN

NEW YORK—There has been an open season for former aides of Richard Nixon to blame him for what they, and he, did during his administration that they now wish were undone. One who is not criticizing the ex-president is his first commander in the war against drugs, psychiatrist Dr. Jerome Jaffe.

He was appointed by Nixon to be the first chief of SAODAP—the President's Special Action Office for Drug Abuse Prevention—and served from June, 1971, until June, 1973, when he retired. Dr. Jaffe, who now lives near New York City and teaches at the Columbia College of Physicians and Surgeons, in Manhattan, shared some of his reminisences of SAODAP with The Journal on the occasion of the drug agency's imminent demise.

Dr. Jaffe, for one, is essentially pleased with his own, and with SAODAP's achievements. He has no quarrel with the motives of the president who made them possible.

Dr. Jaffe confirmed, as essentially correct, Ergil Krogh's assessment of Nixon's motives as being highly political (See story elsewhere on this page). People resent it, Dr. Jaffe said, because the motives of the administration were not pure.

"Well," he said, "I don't need to have pure motives, if I have good behavior .... I don't require altruism as a motive."

Speaking of Nixon, Dr. Jaffe recalled:

"His perception was that the public wants something done (about drugs and crime) and if it can't be done by law enforcement, then we'll give treatment a chance."

The American public, Dr. Jaffe said, was not interested in the health care of "hippies and junkies". But, "they were willing to pay for some of that if it would make their own lives a little safer and less risky."

As the result, addiction treatment services were granted unprecedented administrative priorities and, in a time when money was tight, an unprecedented amount of cash to do the job.

"Once the president says, 'I'm interested in this problem,' it has phenomenal reverberations," Dr. Jaffe said. "Without that, I think it all would have died.

"His message to the (budget-setting) Office of Management and Budget was: 'Don't play games with my man!' He gave me every nickel. He didn't cut it down the middle."

"So," Dr. Jaffe continued, "if Nixon was willing to spend the effort and resources, it seemed fair to me that he get the credit for doing whatever we could do. ...

"President Nixon's administration wanted to reduce crime. From it, we got a system for helping those people who got into drugs get back out."

His own major contribution, he suggested, was to create and win assent to new methods through which this could be accomplished.

A principal achievement, he said, was winning public and administrative commitment to treatment for addicts. Most of the available money was going to law enforcement, but crime was getting worse rather than better. The public believed on the one hand that heroin addiction meant death or enslavement, but on the other hand the American law enforcement and judicial systems were not ideologically prepared to act on this assumption by locking up all users and throwing away the key.

What is more, Dr. Jaffe added, the attitude that heroin addiction is hopeless "largely prevented people from re-entry into society. It made them public pariahs."

Much of his job, Dr. Jaffe indicated, was educational—in the sense of creating alternative ways for the public to think about drug abuse at the same time that these alternatives were being created in fact.

An effort was made, therefore, to establish that some heroin users did not commit crimes; that some who did were criminals before they became users; while some became criminals only because of their addiction, in order to buy drugs.

The problem SAODAP faced, Dr. Jaffe said, was: "How do we help those who are not tied to crime to move back into the mainsteam, while at the same time countering the spreading (counter) view that all users are nice people who need only a little treatment to become paragons of virtue?"

The solution was to create an enormous surplus of treatment opportunities.

"When there is an excess of treatment," Dr. Jaffe explained, "then no one can go before a judge and say: 'I commit crimes to get heroin.' The judge says, 'We have 300 treatment slots in New York City, why don't you get into one?'"

Dr. Jaffe thus claimed credit for the approach to heroin abuses that says:

"We will make treatment so available that no one can say he committed crime because he couldn't get treatment."

The drug abuser thus was offered a choice, and the judge—and the public—provided a basis for determining whether the problem in a particular case was one of crime, or rather involved a drug abuser who would not be before the bar if adequate treatment opportunities were available.

To implement this policy required considerable innovation. Previously, *treatment* had meant, for the most part, incarceration at Lexington, at a cost of $40,000 per bed/year. Little wonder then, he continued, that when SAODAP started there were no more than 16,000 drug addicts in treatment—a tiny fraction of the estimated 600,000 in the U.S. To treat them all at the prevailing high cost per treatment bed would have meant expenditures of billions of dollars—which were not available.

To meet this need, Dr. Jaffe said, he changed the concept of what treatment is for heroin addiction, shifting the unit term from "bed", which is costly, to "slot", which may or may not be. The idea of treatment "slots", he said, was a new and innovative achievement of SAODAP, one that since has become widely accepted. A slot can be an expensive in-patient bed in a locked facility. Or, it can be a place for a patient in day care, a place in a therapeutic community, or—what is much less expensive—the resources to maintain an individual on methadone maintenance.

In the drive to create treatment "slots", Dr. Jaffe said, SAODAP legitimatized methadone maintenance. This required enormous effort, since all of the professionals and agencies that had dealt with drugs and crime by and large opposed it.

To overcome this opposition, Dr. Jaffe recalled, SAODAP had to win agreement from the Justice Department, the Bureau of Narcotics and Dangerous Drugs, the Food and Drug Administration and the National Institute of Mental Health. This was no small achievement.

By mid-1973, when he stepped down, Dr. Jaffe said, SAODAP had spurred the creation of 100,000 treatment slots in the U.S. There then were 80,000 addicts and drug abusers in treatment in them.

Dr. Jaffe was asked what one aim that he had had for SAODAP that he most regretted not having achieved. He thought a moment and said:

"The one thing I would have wanted to do was the creation of a reliable data base so that we could keep track of the input of the various programs and the waxing and waning of the drug problem.

"In a time of simplistic thinking," he said, "you sometimes have an opportunity to make progress on a complex problem."

SAODAP's first chief, Jerome Jaffe

SAODAP's demise

(continued from page 1)

policy decisions. On the law enforcement side, he said, the Drug Enforcement Agency is higher in the Justice Department than NIDA is in HEW. "That certainly is going to be in their (DEA's) favor in terms of evolving federal policies."

SAODAP was created because of the intense personal and political interest of President Richard Nixon in the problem of drug abuse and crime.

The Ford administration, Bucher said, is no less interested in drug abuse than was the Nixon administration. But, he added, the "driving factor" in ending SAODAP's existence on schedule is the new administration's general policy of reducing the number of special offices in the office of the president.

The president's feeling, Bucher said, is that the responsibility ought to be returned to the more traditional line agencies.

Whether there will be any federal coordinating body to replace SAODAP is unclear, Bucher said. There has been some talk that a drug prevention policy task force may be established for the president's domestic counsel. But no definitive action has been taken. In addition, there will continue to exist a small drug management office in the office of management and the budget. This too has a coordinating role.

Has SAODAP accomplished anything?

"I think they did a hell of a lot," said Bucher, who joined SAODAP in 1972. Among its most important achievements, he lists the increase in treatment slots from fewer than 20,000 to more than 120,000 at the peak. Today, he said, there are 95,000 slots, all filled.

A significant achievement, he said, was the improvement in drug therapy, including the acceptance of methadone maintenance and the development of minimal standards for methadone on treatment.

Also important, he said, was the establishment, through federal regulations, of the confidentiality of drug abuse treatment. New regulations that will further elaborate the client's rights of confidentiality will be announced shortly, he said, in conjunction with NIDA.

The ability to obtain data on drug use, abuse, and treatment results, through uniform, computerized information systems, is also a significant advance, Bucher said. Planners now know a little more about the problem, with a little more assurance, he said, and this is valuable policy and program planning.

Early days recalled by White House "plumber"

NEW YORK—For the last five years, the campaign against addiction in the United States has been largely orchestrated—and underwritten—by a federal administrative entity with the oddly august title of President's Special Action Office for Drug Abuse Prevention. It is abbreviated SAODAP, and is subject to a variety of acronymic pronunciations.

SAODAP, it is safe to say, has influenced the professional life of virtually everyone in the addiction rehabilitation field.

It was a creation of the Nixon administration, and with its downfall, the quite human history of SAODAP's founding and early days has tumbled out far earlier than revelations of this sort normally occur.

One from whose lips they have tumbled is Egil (Bud) Krogh, an associate of Nixon advisor John Ehrlichman. Young Krogh, one of the White House "plumbers" who served time for having authorized the burglary of the office of Daniel Ellsberg's psychiatrist, was instrumental in founding SAODAP. Now on the lecture circuit—for W. Colston Leigh, Inc.—he is talking candidly, with the help of official memoranda that remain in his possession, about his government work, particularly SAODAP.

In a talk at Columbia University late last year, he said the genesis of SAODAP was the decision by Nixon, in 1969, that crime in Washington, DC, had to be stopped. Krogh recalls calling the mayor, Walter Washington.

"(I) asked him to stop crime and he paused a few minutes and said 'Okay'. And that was about it."

Needless to say, crime did not stop, and several months later the White House took over the job. Says Krogh:

"Basically, the concern for crime in the District of Columbia was the basic energy that led to the development of a national drug control program."

A major link between crime and drugs, Krogh said, was a study that showed that 68% of the inmates in the DC jail were heroin addicts or users. Another was surveys showing that drugs were perceived by the public as one of the nation's most burning social issues. As a result, Krogh said, the war against drugs became a part of Nixon's moral crusade.

Drugs thus gained a top priority at the White House. Krogh described one early brain-storming session:

"This idea came up one evening in my office. We said, 'You know, we ought to think about something that is going to be taking action.' Somebody said, 'Yeah, but it ought to be special action—there are a lot of action programs. Why don't we call it a special action office?'"

And so SAODAP was born.

"It was a clear crime control, crime prevention orientation," Krogh said.

President Nixon, who met with the drug war planners, issued his declaration of war on drugs in June, 1971. The Turkish opium farms were a major preoccupation, Krogh said, and an invasion was considered, briefly, and then rejected.

Krogh shed some new light on Nixon's rejection of proposals to legalize marijuana. When National Institute of Mental Health chief Dr. Bertram Brown was quoted in the press as advocating legislation, Krogh said, Nixon "just exploded and said, 'Nobody in my administration is going to be suggesting that we legalize it in this way."

Dr. Brown ultimately kept his job. When a Federal Commission on Marijuana and Drug Abuse recommended legalization, Krogh said, Nixon simply did not read the report.

Within two years, Krogh said, Nixon felt that he had made as many political points as there were to be made on the issue of drugs, and his interest waned. Krogh said:

"He did see drugs as political points." ZIMMERMAN

The 'rounds' system

...None for my friends

By ALAN MASSAM

LONDON: A growing chorus of concern about rising rates of alcoholism among young people and women and the appearance of "skid row" areas in major cities, has finally produced a response from the Department of Health and Social Security.

Chief worry was the apparent delay over the setting up of the department's Advisory Committee on Alcoholism, promised last September.

Names of members of the committee have now been announced. It will be headed by Professor Neil Kessel of the University of Manchester and will advise the department for an experimental three-year period.

The committee's remit is to study services relating to alcholism and, where appropriate, promote their development.

It will also appoint a special sub group to help plan and develop better facilities for homeless alcoholics.

Professor Kessel is a founder member of Britain's Medical Council on Alcoholism and a member of its executive committee. His publications include the well-known book *Alcoholism* (published jointly Kessel and Walton in 1965 and 1966), a revised edition of which is expected to appear shortly.

Travers Cousins, a leading member of the Avon Council on Alcoholism, Bristol, believes one way of dealing with the growing problem of alcoholism in Britain would be to reintroduce the "no treating" legislation which stopped the buying of "rounds" in public houses during the First World War.

These regulations made it illegal for one person to purchase intoxicating alcoholic beverages for another on licensed premises.

Mr Cousins says: "Unless we examine this type of control, we must accept:

1 Greater need for government money to be spent by the National Health Service on alcohol-related diseases and rehabilitation of alcoholics;

2 Increased demands on existing and projected hospitals and medical personnel;

3 An increase in the prevalence of alcohol-related disease and death;

4 An increase in costs to business and industry, the police, courts and prisons, and an enormous cost in disruption of families.

The Journal of the Medical Council on Alcoholism says in an editorial in its Spring issue that the extent to which the "rounds system" figures in the drinking habits of the present generation must be conjectural although visible evidence supports the belief that the majority of people who drink in public do not do so alone.

"That group drinking is playing a leading part in the increasing amounts of alcohol being consumed . . . seems certain, despite a paucity of objective investigations," the journal adds.

"The studies made by Travers Cousins have convinced him that treating constitutes the greatest pressure on people to drink too much, and that it calls for drastic preventive action which might include the reintroduction of the 'No Treating' Order of 1916.

"Despite the remarkable success of this and other measures introduced during a rave wartime emergency, it cannot be anticipated that it will find favor in peace time, even in the presence of what many would call an emergency of another kind."

(The Irish National Council on Alcoholism recently launched a vigorous campaign against the 'rounds system' and it has received considerable support from press, radio and television, and the church. It says it does not look for dramatic results, but cooperation from many quarters has come to light and the campaign is expected to gain momentum and bear fruit.)

The Journal of the Medical Council on Alcoholism says inquiries among moderate and not-so-moderate social drinkers confirm that an appreciable number dislike drinking in the large groups in which they often find themselves, against their better judgment, because to buy their own drinks would be deemed unsociable.

"Many a recovered alcoholic, recalling his past, has spoken of the delusive attraction of the drinking sessions at which tongues are loosened and the raconteur and humorist holds the floor.

"It is ironical that the lone, inebriated figure seen at the end of the bar, might have once been a leading light in such a group, until the onset of the 'lonely disease' made his presence unacceptable."

Personality patterns in pre-alcoholics

ANGER, FRUSTRATION, anxiety, hostility—anything which leads to stress—could be considered the "Achilles' heel" of the alcoholic, a Chicago alcoholism expert believes.

Margaret A. Fleming, treatment coordinator for the Mercy Hospital Alcoholism Treatment Unit, observed that the alcoholic's inability to cope with tensions could be related to certain patterns of unstable behavior that she has identified in both pre-drinking and post-treatment years.

A survey of 64 former patients disclosed such a pattern in their pre-drinking education, she said. Of the 42 in the group who had gone beyond the elementary level, only eight actually completed the level undertaken, she reported.

Similarly, post-treatment data showed that all 64 members of the group were employed at the time of the survey, but that 24 had returned to drinking and nine members of this group reported having held from two to five jobs since completing treatment, she said. None of those who were not drinking had changed jobs.

"It would appear that the abstinent group was demonstrating job stability, whereas many of those who returned to drinking continued to be as unstable as employees as they once had been as students," she said.

Another difference between the two groups was that more of the group that returned to drinking had stopped attending AA meetings than of the non-drinking group, she said.

The findings suggest in-patient treatment may only provide a temporary interruption in a drinking pattern and, by itself, is seldom capable of producing abstinence, she said. Introduction to AA while still in treatment may be essential to maintaining abstinence, she continued, since active involvement may produce a gradual shift of attitudes and values.

The results showed that alcoholics who stopped drinking did not develop problems in other areas but were more likely to be employed steadily at the same job, going to AA meetings on a regular basis, amd feeling more positive about themselves and about others than those who returned to drinking.

The results raise such questions as whether there is a "pre-alcoholic personality" or whether there are certain personality traits which relate to a lack of endurance or perseverance, she said.

"Increasingly," she said, "evidence points to the existence of a pre-alcoholic personality which, when combined with certain physiological and sociocultural factors, may eventually produce alcoholism in many high-risk youngsters."

Headache money

TORONTO—Canada's Migraine Foundation which among other things is investigating the potential for drug addiction in migraine sufferers, has received a $10,000 grant from Toronto's Hospital for Sick Children.

The money is a one-time grant in support of the first year of operation of the Toronto-based foundation which was formed in July, 1974.

Migraine sufferers, or migraineurs as they are frequently termed, are often required to use very potent drugs. With the assistance of the Addiction Research Foundation of Ontario, the Migraine Foundation wants to answer such questions as: Do migraineurs sometimes become drug addicts? If so, when? How can a migraineur in mid-attack convince a doctor he or she is not, for example, a heroin addict?

Although the $10,000 grant is not for a specific purpose, it does highlight the need for early intervention and treatment, according to Stuart MacKay, president of the foundation.

Treatment in childhood could eliminate "decades of suffering" for migraineurs, he said.

IRS agents 'programmed' to drink

THE INTERNAL Revenue Service in the United States operated a secret school in which undercover agents were tested with "liquor and women" to see if they could resist disclosing their own identities, according to The New York Times.

The Times (April 14) said the program was referred to as "stress seminars" in some IRS circles and quotes one official as saying the program went on "at least until 1969 and probably longer".

A Federal law enforcement official was quoted by The Times as saying: 'If I've got to teach an agent how to drink and to program him not to talk when he's drunk, he is not undercover material. He found the idea of the school 'laughable', according to The Times.

The revenue service is under investigation by three Congressional committees looking into the use of informants, electronic surveillance techniques, and preparation of political dossiers.

Incest factor

(Continued from page 1)

private with each female resident. Dr. Densen-Gerber stressed that in all cases there was a trusting relationship between the staff member and the resident.

Of the 118 women interviewed, 52 admitted to having had incestuous relationships. In contrast, when Odyssey's female staff members answered the questionnaire, 5% said they had had incestuous relationships. Odyssey House staff consider this to be representative of a national cross section.

Apologizing for the "primitiveness" of the study, Dr. Densen-Gerber said: "It was the first. We did not expect to find 44%. Dealing with that concept is almost . . . well, just almost unbelievable."

She said studies on incest are almost non-existent in psychiatric literature. When they do exist, they tend to focus on individual cases.

"We never look at it as a very important factor that brings

ILLEGITIMACY

women to alcoholism, drug abuse, acting out, running away, prostitution, illegitimacy, venereal disease—we never see trends."

While precise details of an incestuous event have a considerable bearing on how the law will deal with it, psychiatrically the fact that it took place at all is what matters, she said.

"From the point of view of what happens to the child, even if she consents, she is damaged," said Dr. Densen-Gerber.

In the Odyssey study, the "most powerful dynamic in all cases, the primary thing they reported again and again and again was helplessness. They could not control (the situation)." And the necessary external controls were not there, she said.

"Many would not have been fed had they not co-operated. The only kind of closeness they learned was sexual.

"If we don't consider the female child, when we get to the female adult, she is so damaged, so traumatized—and she repeats it with her own children—we can't get out of it."

In the study, incest was defined as inappropriate sexual contact with a person who would be considered ineligible because of blood or social ties, i.e. fathers, stepfathers, grandfathers, uncles, siblings, cousins, in-laws, and quasi-family members, including parental and family friends.

"Incest taboo applies . . . to all these and the partner represents

PROTECTION

someone from whom the female child should rightly expect warmth, protection and sexual distance."

The women surveyed were from throughout the US. Fifty-three per cent were white, 40% black, 4% Hispanic and 3% native Indian. Thirty-six per cent were Roman Catholic and 42% Protestant.

The 44% admitting incestuous relationships reported a total of 93 different incestuous partners of whom 85 were male. Twenty-nine reported only one incestuous partner and 23 had multiple partners. The average number of partners was 2.6.

"Those who had sexual relationships with female partners were all in the multiple partners group and the female incestuous partnership began after the woman had been introduced to incestuous behavior by a male partner within her family."

Thirty-seven per cent of the cases involved intercourse, the remainder involved other behavior.

Incest was divided into two types—cross-generational and peer-generational.

"When the partner is an authority, a trusted parental figure, such as the family doctor, the little girl has a different reaction than when it is play with her brother.

"We are not particularly concerned—though it says something

PEER PLAY

about the family life—about peer-generational play. We are concerned when it is incestuous behavior with a male, being an adult male, and it being a female child."

In the cross-generational group, 12% of the cases were with fathers, 9% with stepfathers, 2% with grandfathers, 17% with uncles and 17% with quasi-family members.

"There is a great need to confront the cases of incest to develop tools for detection and prevention and, of course, tools for treatment," said Dr. Densen-Gerber.

"With the current concern of women for women, this extremely devastating form of violation, namely statutory rape of a child by a parent figure, with the permanent psychology sequellae, must be faced and dealt with.

"Much further work must be undertaken in an area which seems taboo even to us in investigation," she said.

Among other things, future Odyssey investigations will study incest in male children.

Smoking twins needed

(Continued from page 1)

symptoms, may not be doing themselves serious harm—at least in terms of bronchitis and emphysema. (He stressed the team is not discussing lung cancer).

On the basis of the test results, the team suggests there may be two groups of people—those who react to smoke by developing symptoms and poorer lung function; and the non-reactors.

The difference in the two groups could be accounted for by habit: They may smoke different types of cigarettes; may inhale differently; may throw half-smoked cigarettes away.

But, there could also be a genetic factor. Hence the search for identical twins.

As identical twins share the same genes, then if the genetic theory is correct, either both twins will smoke and react or both twins will smoke and not react.

Working on the twin study are Dr Noe Zamel, associate professor of medicine and head of the tri-hospital pulmonary function laboratory; and Dr Paul Man, a research fellow in the graduate program which trains specialists in chest diseases.

New campaigns urge public to "Slow Down"

Posters and pamphlets designed to raise level of Ontario public awareness

By MILAN KORCOK

USE OF multi-media techniques to cut into the growing public consumption of alcohol is becoming a highly visible activity of health ministry communicators in Saskatchewan, Ontario, and to a lesser extent, Manitoba.

Within the past six months (beginning with Saskatchewan in mid-1974) slick, well-financed campaigns have been mounted to get the average drinker to slow down.

In Saskatchewan, the public health department's AWARE program got underway with a combination of television and radio commercials, newspaper and magazine ads, transit cards and roadside billboards. So far, 30 television and four radio commercials have been aired, and ads have appeared in all publications edited in the province.

Don Leitch, director of AWARE told The Journal that $500,000 (plus more than $100,000 from the federal government) was expended on the program in fiscal 1973-'74. The 1975-'76 spending will rise to $739,000 (plus whatever Leitch can squeeze out of Ottawa, if anything).

The Saskatchewan program concentrates its ads and commercials in five broad zones: drinking and driving, teenage drinking, alcohol as a drug, negative drinking patterns, and alcohol and industry.

The key objectives are to raise the level of public awareness about the effects of alcohol, and reinforce social attitudes that would lead to a changing of those patterns.

Ontario's program, which is expected to cost about $500,000 in its first six-month period and up to $2½ million by the end of its first three years, is described as a "positive, health oriented approach, directed to the average consumer—not necessarily the problem drinker or alcoholic."

Planning for the program originated more than two years ago with proposals made to the health ministry by the Addiction Research Foundation. In implementing the program, both the ARF and the Ministry of Education were involved in its design and message content.

The program, unveiled in a day-long series of press conference, includes:

- Pamphlets on the physical effects of alcohol. Prepared for the general public, these pamphlets will be distributed via health information centres, mailings and other means.
- Three 12-minute films for general audiences, produced by professional film production companies.
- A series of 11 radio and five television commercials based on the theme "You are your own liquor control board." Produced by independent advertising firms, these commercials stress the wisdom of individual choice in establishing drinking practices.
- Pamphlets and posters on the theme "Mix a little thinking with your drinking." These are to be distributed to business and industry for use in plants, offices, and union halls. They stress the costs of alcohol in terms of household budget, as well as in terms of social health and welfare costs.
- A series of pamphlets and posters produced for young people. They are designed to make an impact on the youth audience at a time when young people are forming their drinking habits and attitudes.

In unveiling the program, Ontario Health Minister Frank Miller stressed a deliberate attempt to stay away from scare tactics and to promote positive attitudes to healthy drinking styles.

Underlying the development of the program is a "cause for growing concern", said the health minister.

"(People) are drinking to an extent that is doing all round damage, not just to themselves, but to the productivity of the province, to the health care system, to their families, to fellow workers, to everyone."

"There's no way, especially in times like these, when anyone can afford a hangover of a size like that," declared Miller.

The Ontario program is clearly intended to gain a high visibility. The five 30-second television commercials, for example, are slated to run for at least 650 exposures. They will run in prime time periods (paid for at the going rates), as well as in public service slots.

Most of the materials have also been prepared in French.

Spokesman from the ministry say the program will be promoted across the province to various professional and business organizations. Anyone requesting the materials from outside Ontario is to be charged for them.

The only major gap in the Ontario program is failure to use print ads in any publications. Director of Communications for the health ministry, Jim Bain, said that such ads would be included in future phases of the program.

A key ingredient of the Saskatchewan program, one which puts it several steps ahead of the others, according to Leitch, is the evaluation process that has been built in. Before the program was begun, AWARE commissioned Dr. Paul Whitehead, professor of sociology at the University of Western Ontario to run baseline studies defining the drinking patterns in the province. These studies will be used to gauge effectiveness of the program at various points in time.

Some samplings of public reaction have already been made and, according to Leitch, they show that the program is making the desired impact on Saskatchewan drinkers.

Of 551 responses, 80% claimed recognition of some parts of the program, and of these, 79% were in favor of it and thought it was good. Only 2% of respondents were against the idea of the program.

Of those who responded, 50% felt the program had already had some effect on drinking habits, and 8% felt it had changed their own practices. Noteworthy in this latter group was that many of those who claimed it had changed their drinking activities were males, under the age of 25.

"We put a lot of effort into measuring practices and attitudes before putting this program into effect," said Leitch. "Otherwise, I don't know how we could judge its effectiveness."

The Manitoba program, modest in comparison to both the Saskatchewan and Ontario efforts, was arranged in close cooperation with AWARE.

Manitoba negotiated a cost-sharing deal for the production of some of the Saskatchewan materials which it then adapted for its own purposes.

Saskatchewan program concentrates its ads and commercials in five distinct areas

Mid—Florida Centre for Alcoholics

. . . a model treatment program

By TOM HILL

ORLANDO, FLA.—When the National Institute on Alcohol Abuse and Alcoholism (NIAAA) made its well known movie, "America on the Rocks," it sent its cameramen down to this east central Florida city to photograph what is widely acknowledged as one of the best alcoholism programs in the country—the program operated by the Mid-Florida Centre for Alcoholics, Inc., a non-profit organization set up in 1970.

The MFCA program has served as a model in more ways than this, executives of the organization told **The Journal** in a recent interview. It also ranks near the top of its class as far as effectiveness and efficiency of operation are concerned.

An evaluation of alcoholism treatment centres conducted for NIAAA by the Stanford Research Institute, an independent research organization, attests to the effectiveness of the centre's work and the efficiency with which it is performed:

• Of the programs monitored, MFCA had the highest impact in its class on employment of patients after treatment. Some 84% of those considered to be in the work force were working at the end of 90 days and had increased their income by 22% over that just prior to intake (compared to national figures of 78% employed, with only 2.5% increased income).

• MFCA patients, who tended to have a higher intake of liquor per month before treatment than the average for other centres, drank very much less than the average after treatment, (0.5 ounces per day on an average of six days in the month, compared to a national average of 1.3 ounces per day for 3.2 days).

Other figures in the continuing study revealed MFCA had the lowest average expenditure per person treated, the highest number of persons served per staff member, and the largest caseload of all alcoholism treatment centres in its class, which is based on area population.

"We were actually the first program in the country to be funded under the 1970 amendments to the Regional Mental Health Centers Act," MFCA executive director Betty Jo McLeod told The Journal.

"A group here that included representatives of some 16 major public and private agencies had spent the previous two years surveying the community's alcoholism services and needs and developing a program to meet those needs. So we were all ready to qualify for federal funding as soon as it became available."

Planning ahead appears to be one reason for the organization's consistent successes. Another is undoubtedly the realistic approach of the professionals who run the centre—among other things, they manage to keep enough options open to allow them to deal with, or at least adjust to, setbacks that may frustrate their ambitious planning.

And setbacks have occurred. Last year they lost the new headquarters building they were about to move into.

Betty Jo McLeod

"We were left with this whole program and no place to go with it," Miss McLeod relates. "We had 30 days to get relocated and back in service or we'd lose some of our grant funding. We put in a harried 30 days."

No hospital-like facilities were available. What was available in mid-town Orlando was a converted old residence that could accommodate the administrative offices, outpatient services (including outpatient group therapy) and information and referral facilities. Space for the inpatient service, the day care program and some other facilities would have to be found elsewhere.

The solution to the problem was a ground floor wing in one of the many new motels built during the Disney World construction boom. Approximately 10 miles of urban and suburban Orlando separate the two groups of facilities—but the program continues without a hitch.

"For the first time we're operating a split program," says Miss McLeod. "But we see it as temporary—sort of a holding pattern. We're now looking again at the idea of building a building, as there's simply nothing available that would be suitable."

Another setback occurred at much the same time. One of the centre's pet projects was a subacute detoxification unit in St. Cloud, a town of some 5,000 people in one of three counties (Orange, Osceola, and Seminole) served by the centre.

This unit operated "very successfully" for almost a year but had to be closed down last fall because of a snag in the funding arrangements, reflecting differences between counties and the state government over the question of sharing. The situation is still fluid and officials hope the differences will soon be resolved.

But the enforced closure of the operation was a disappointment. Says MFCA's community education coordinator, William S. Chambers, Jr: "After it had been going for six months, we found it had served more people in the last two months of that period than in the first four. And the statistics continued to build in much the same way for the whole eleven months."

"The policemen also liked it," says Miss McLeod, "because they don't enjoy being tied up for hours, as can happen if, for lack of proper special facilities, they have to go to a hospital emergency room with the intoxicated person who needs treatment. "Emergency rooms are chronically overcrowded these days and, of course, the real medical emergencies have to be handled first. So the drunk sits in the corner, and the doctor in the emergency room doesn't want the policeman to go away and leave him there. So the policeman has to wait around until the medical emergencies are all dealt with and his charge can be taken over by the emergency room staff.

"When you have these alcoholism units set up properly . . . a police officer can leave the intoxicated person and be on his way within 10 minutes, by which time the intoxicated individual is already started on a treatment program."

The main programs of the Mid-Florida Centre for Alcoholism have not, however, been affected by the setbacks.

The centre offers a comprehensive list of services based on the general philosophy that detoxification alone is not sufficient treatment for alcoholism but must be followed by long term rehabilitation.

"A lot of alcoholism units aren't set up to do rehabilitation," says Mr. Chambers, "but we attempt to get the rehabilitation started from the moment the individual comes in, while he is undergoing detoxification.

"We call this 'intermediate rehabilitation' because we don't feel by any means that the two weeks we have him here really assures him of continuing sobriety.

William Chambers

"So we encourage him to go into some form of after care—our outpatient program or perhaps AA affiliation and activity or any of a variety of sources of support following the two weeks of treatment here."

The individual is the focus of really intensive rehabilitation efforts during the two weeks he is an inpatient.

"We take the time he would be wasting if he were undergoing detox in a hospital," Miss McLeod explains, "and we give him didactic education in alcoholism. Alcoholics are notoriously ignorant of their own problems. Each one of them, when he comes in, thinks he's the only guy in the world that's controlled by liquor.

"So we try to give him the best knowledge available, based on research throughout the world, about alcoholism, its antecedents, its physical effects and so forth.

"Then we move him from that into the area of trying to understand himself as a human being, then from there into interaction—the way people relate to each other—correlating this with some understanding of how alcohol is used as a coping mechanism in life.

"By the time we get through with the patient in this two week sequence, he's pretty knowledgeable and we've given him the tools he can work with in handling his problem even if we never see him again."

In most cases, however, the centre does see the patient again, usually in one or more of the long term rehabilitation programs. There are also some repeaters. Those back a second time for detoxification go through essentially the same rehabilitation program but, being with a different group, also get different experience.

Rehabilitation groups are limited to 10 people. Usually one staff member handles such a group, but occasionally two will work together.

An individual counsellor is also assigned to every patient, to work specifically with him through the two weeks. The ratio of all staff to patients is approximately 1 to 6.

A flexible format is used for the group therapy. "It's a free flowing thing," says Miss McLeod. "The therapist responds to the needs of the patients as manifested at the time. This may be a unique aspect of our program."

Outpatient clinic services form an important part of MFCA's activities. Some 13 outpatient groups meet in the evenings at headquarters each week. Each group comprises a psychotherapist, a counsellor and up to 10 patients. There are groups for husbands and wives together (individual conjoint therapy is also available when indicated), groups for only the husbands or wives of alcoholics and several groups of alcoholics themselves. Also, although there is no official affiliation with Alcoholics Anonymous, the centre works closely with various AA members and groups.

There is also a "diagnostic group" for people who enter through the DWI (driving while intoxicated) program. These are people who have never gone through a program and usually are not convinced they need to.

Other MFCA activities include community outreach—dispensing information and providing limited services to outlying areas.

Listing of drug prices prelude to public advertising

OTTAWA—The federal government is finally changing its drug regulations to allow the posting of comparative prices in drug stores of most prescription drugs.

The move, a first step towards public advertising of prescription drugs, was in effect forced on Ottawa when a number of drug stores in Montreal and Toronto started doing it, despite existing federal and provincial prohibitions.

But the federal government's regulatory changes, which should be made public soon, will continue to prohibit the posting of prices of certain drugs and even certain over-the-counter medicines that are either hazardous or potential drugs of abuse.

Narcotics, amphetamines, and barbiturates, and other related controlled or restricted drugs, will remain verboten, to ensure that price posting does not encourage abuse of these addictive drugs, according to federal health officials.

Certain over-the-counter products, supposed to be used only on the advice of a doctor, will also be kept off the price lists. Curiously enough, these products will continue to be displayed where anyone can choose different brands and compare prices.

The idea of allowing comparative price posting in pharmacies has been advocated by the federal health department for several years.

But since Ottawa has the power only to allow, not to force, comparative pricing, it was left to the provinces, in particular the provincial colleges of pharmacists, to take the first step to allowing the practice.

Until recently, the main argument against such a move from some pharmacists was that it would promote abuse of some drugs, particularly addictive drugs.

While the federal government does not believe comparative posting would encourage abuse of drugs, since a doctor's prescription must still be obtained, it removed what it thought was the heart of the controversy by keeping narcotics and the controlled drugs under a prohibition.

Addicts "conning" doctors

OTTAWA—When heroin is scarce, addicts have discovered they can "con" doctors into prescribing an opium derivative called Dilaudid to tide them over.

The Ontario College of Physicians and Surgeons has again warned its member doctors about being "conned" and added it is against the law for a physician to prescribe a narcotic except to a patient under his or her professional treatment.

"Dilaudid should not be prescribed in the treatment of drug addiction," because Dilaudid is not a recognized drug in the treatment of addiction.

Contrary to previous warnings about the drug, "a member of doctors have been supplying prescriptions which are getting into the illicit market," the College says.

Dilaudid is the trade name for the opium derivative hydromorphine and is considered a highly acceptable substitute for heroin for addicts.

The drug is normally used in medicine as a painkiller and as a method of controlling coughs.

The College says that "addicts are 'conning' physicians into writing prescriptions by admitting to heroin addiction and requesting Dilaudid to help them break the habit."

Pre—Olympic warning

OTTAWA—With preparation and training of amateur athletes already underway for the 1976 Olympics, the Ontario College of Physicians and Surgeons has warned doctors not to prescribe amphetamines or amphetamine-like drugs to improve the performance of athletes

In its report to physicians, the College notes that such use of amphetamines is forbidden under the Food and Drugs Act.

Amphetamines were limited by he federal government to a very restricted number of uses after it was decided the drug was addictive and overprescribed in Canada.

The Ontario College also notes that related drugs such as Ritalin, Tenuate and other stimulants, "although available on prescription, should not be used for this purpose (improving the performance of athletes) and in fact are prohibited by the 'doping rules' of athletic associations."

The college says that "since these drugs may be widely used by trainers in other countries, upon coming to Canada they may expect our doctors out of courtesy to provide prescriptions for members of visiting teams.

"A firm refusal softened by a tactful explanation will be required."

Hornblass backs out following Lib threat

JEROME HORNBLASS, commissioner of New York City's Addiction Services Agency, and would-be moderator of a Workshop on Women's Concerns at the conference, cancelled the session when a group of women threatened to picket it.

The workshop scheduled for the third day of the four-day conference, was cancelled by Hornblass when he learned a group of women "were concerned" that he and not a woman was to be moderator.

One woman delegate said about 40 women had planned to picket the session and that two women who were to participate in the panel discussion had decided against it.

She said opposition to the commissioner's appearance began soon after copies of the program were distributed on the first day.

Alberta L. Henderson, special assistant for women's concerns in the office of the director of the National Institute on Drug Abuse, and co-chairperson of the conference, said she was relieved that a confrontation that was potentially "disruptive" had been avoided.

Mr. Hornblass moderated another program on Treatment in New York City—an indication of National Trends.

About 3,000 people, most of them from the United States, attended the conference which focused on drug abuse prevention methods, treatment and rehabilitation, and on major issues in the field.

Apparent as a new and growing force at least year's Chicago conference, women commanded perhaps even more attention this year—as speakers, delegates,

Jerome Hornblass

workers in the field, and as addicts and addict-mothers.

That fact was not critically affected by the cancellation of the Workshop on Women's Concerns. Other workshops focused on such subjects as Women in Treatment; Women and Drugs; Women and Addiction; Women—Special Problems; and The Female Client: Treated or Mistreated?

Next year's conference chairperson is Dr Joyce Lowinson, director of the Drug Abuse Service, Albert Einstein College of Medicine, Bronx State Hospital, New York.

Cocaine studied

INTRAVENOUS COCAINE produces significant psychological and physiological effects in humans at dosages of 10 mg and 25 mg, according to a New York Medical College study.

The researchers claim their study is the first to investigate the effects of cocaine in humans in a controlled situation.

"Although the basic systemic action of cocaine is known to be sympathomimetic, the magnitude and duration of its effects at different doses has not been systematically studied," Dr. Richard B. Resnick told said here.

"There have been no controlled studies of physiological or behavioral effects of cocaine in individuals who are free of serious organic disease or psychopathology."

Dr Resnick and collaborators, from the division of drug abuse research and treatment, department of psychiatry, assessed physiological and subjective effects over 30-minute observation periods of single doses of 10 mg and 25 mg cocaine by intranasal and intravenous administration.

The study is the initial one in a series aimed at identifying and understanding cocaine's systemic effects and determining if treatment is indicated and if so what kind.

Physiological parameters measured were heart rate, blood pressure, respiration, oral temperature and handgrip strength.

Subjective effects measured consisted of "high", pleasantness, speeding, hunger, strength, and acute effects. Subjects rated degree of sensation on various scales and acute effects were assessed by the number of positive responses to 32 statements, including "I have a weird feeling", "My memory seems sharper to me than usual" and "I feel less discouraged than usual".

Cocaine administered through the nose produced measurable effects only at the 25 mg dosage. Blood pressure rose and subjects reported a very mild and somewhat pleasant experience. The effects were maximal 10 minutes after the drug was given and were still evident at the end of the observation period.

Cocaine injected into a vein produced significant dose-related effects on three of the physiological measures and all the subjective measures—except strength.

At the 10 mg dosage, the heart rate rose an average of 23 beats per minute; systolic blood pressure increased 13 mm; and diastolic blood pressure, 5 mm, which was not significant, said Dr. Resnick.

Following 25 mg intravenous cocaine, heart rate was +32 beats/min; systolic blood pressure was +26 mm; and diastolic blood pressure was +14 mm.

The onset of these effects occurred within two minutes and peaked within 10. Onset and intensity of the physiological changes corresponded with the onset and intensity of the subjective changes.

At the end of the observation period, almost all subjective effects returned to normal except a lack of hunger which persisted.

Physiological changes were still present 30 minutes after the drug was administered. After the acute effects subsided, almost half of the subjects reported feelings of anxiety or depression.

Dr Resnick is associate professor and director of research for the division. His collaborators were Dr Richard Kestenbaum, assistant research professor and associate director of research, and Dr Lee K Schwartz, a researcher.

ANNE MACLENNAN

reports from the

National Drug

Abuse Conference,

New Orleans, La.

Alcohol and narcotics

A minimal interaction

A CHICAGO team has warned against too glibly "lumping alcoholics and narcotics together clinically".

For one thing, "from our observations in our own setting the serious interaction between these two agents is minimal," they say.

Furthermore, there is a danger of talking addicts into alcoholism.

"In view of the current talk about alcoholism, many patients may be beginning to ask themselves is not alcoholism to be an expected outcome or concomitant of narcotic addiction?

"We must be especially careful not to injudiciously help progagandize them into such a self-fulfilling belief at a time of special susceptibility."

The team, Drs. Jordan Scher, Kenneth Smith and Suck-oo Kim, of the National Council on Drug Abuse and the Methadone Maintenance Institute in Chicago, made an intensive study of 628 of 2,000 addicts seen at the Methadone Maintenance Institute clinic over the past three years.

The study was aimed at evaluating misuse of alcohol in conjunction with, or as a result of, addiction.

Of the 394 patients who admitted using alcohol, 62% admitted they had first drunk before involvement with narcotics and 38% said they had first drunk after becoming involved with narcotics. Thirty-five per cent said they had drunk to the point of stupor and of these, 15% said it had happened on more than one occasion.

Eighteen per cent admitted combining alcohol with other drugs such as marijuana and downers.

Of those who admitted drinking, the researchers estimated 5% had a serious alcoholic problem and about 11% more were heavy drinkers and potential alcoholics.

Among the heaviest drinkers, average age was 36 years, 10 years older than the average for the whole group.

"This would suggest either their increased alcohol use was related to their older age or alcohol may be a substitute or enhancing factor in use of drugs, as addicts get older."

"It was the younger patients, a proportion of whom combined alcohol and polydrugs, who often had fewer skills, less of a work history and more of a tendency to misuse combinations of alcohol and polydrugs," the team reported.

Although a number of the patients admitted simultaneous use of alcohol and narcotics, these drugs did not seem to be mutually stimulatory. It also did not appear that the serious misuse of narcotics necessarily entrained an equally serious misuse of alcohol.

In many patients during detoxification, or shortly after, there was a transient increase in use of alcohol. When this increase occurred, it was generally self-limited to a period of a few days to a few weeks.

Patients who did not have a severe drinking problem were usually older and had the heaviest family responsibilities and job pressures. Most of those with a serious alcohol problem said they had always been heavy drinkers. In many cases, so had their parents. In about 7% of the entire group, there was a history of second or third generation narcotic addiction as well.

"Aside from the transient increase in alcohol misuse in those in the process of detoxification, it is our impression that narcotic addiction in and of itself, does not promote heavy drinking or alcoholism as such.

"Nor is there a cross compulsion in the majority of these patients between these two agents, from our observations."

"Drinking in the American population at large seems to be facilitated by a number of factors—a familial history, presence or absence of a broken home, marital problems, financial problems, pressures of work or achievement, an effort to self-treat an underlying psychiatric condition, an effort to suppress anger, to facilitate social intercourse, and others.

"Drinking in our addicted population seems to be primarily a social phenomenon and one essentially leisure-related," said the team.

The researchers said the population of the Chicago clinic may be slightly different from that of other clinics in that there is a high percentage of the patients working and self-supporting. In other clinics, where there are few patients with jobs and or skills, and perhaps a greater number of leisure-oriented individuals, the frequency of polydrug use and alcohol use may be higher, they said.

"One wonders whether issues such as excessive leisure, job frustration, absence of job or job skills, and a seemingly bleak future, may not have more to do with the reported much higher incidence of heavy drinking and alcoholism in other clinic settings where narcotism is treated.

"We seriously wonder whether it is not a necessary cross, or sequential relationship between narcotics and alcohol per se, so much as other social and personal factors which may be of far more significance in accounting for the level of reported cross-addiction.

"A population that is deeply frustrated, not only by its inability to divest itself of addiction but also by its inability to make serious social and upwardly mobile changes, may be very ripe for the misuse of many different types of drugs simultaneously, not the least of which would be alcohol.

Unplanned middle-age invites alcoholism

A LITTLE work, a little play, and sex: For men and women in the aging years, that is probably the best formula for avoiding alcoholism, according to American psychiatrist, Dr. Leon Saltzman.

For those approaching retirement years, his message is: Plan ahead.

"Retirement without adequate preparation for alternative activities may lead to boredom, loneliness, and feelings of worthlessness," said Dr. Saltzman, deputy director, Bronx Psychiatric Centre, and clinical professor of psychiatry, Albert Einstein College of Medicine.

Such feelings, he said, may lead to depression which in turn, may lead to alcoholism.

"The crisis years in the absence of responsible involvement in some activity, be it work or play, lend themselves to depression or its equivalent often ending up in excessive drinking to a point of alcoholism."

The relevant issue in both sexes seems to "refer to the marked effects of the reduction or sudden termination of hitherto active functioning either in professional or domestic roles", said Dr. saltzman.

"In the aging crisis, for many of us the difficulty lies in the unfortunate assumption that a productive existence is impossible in the declining years."

While the prescription for prevention of such difficulties is comparatively simple, he said, the program to carry it out is "enormously difficult" in a society "where only the young and the active are rewarded with both financial and social acceptance".

There should be programs of community education, reforming and restructuring of social security laws, improved retirement programs by organizations, and altered attitudes towards the aging, "particularly those in the years from 45 to 70", he said.

"These are the most productive years in the sense that the individual has now arrived at the height of his skills in his occupation or profession and can be a very effective participant in any program, even if he is not as physiologically capable as he was in the earlier years.

"In addition, misconceptions about sexual activities need to be clarified since the aging years are not associated with a loss of sexual interest but, in fact, may be associated with an increased sexual interest even though there may be decreased frequency. There is surely the continued capacity for full and total sexual enjoyment."

While this applies to both male and female, for the female "it may also be a period of greater sexual enjoyment since there is no longer any need to restrain or to inhibit one's sexuality because of children and other social restraints."

For both men and women, although often at different ages, there are many disruptive elements whether they are single, married, with or without families, said the psychiatrist.

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Equal time for women

FOR THE addictions field to believe that the call for attention to women's specific needs and problems is a middle-class phenomenon that can be taken lightly, is wrong.

Slowly but certainly, the mistake of lumping women alcoholics and addicts with men is beginning to haunt us. That we ignore them at our peril and, more important, at the peril of the next generation, was dramatically illustrated in a paper presented to the National Drug Abuse Conference in New Orleans.

Of 118 women in 44 therapeutic communities, 44% had had incestuous relationships by the time they were 15 years old. One can only surmise what sort of homes those children lived in, what other relationships they had.

But today, some of *their* children are in custody or treatment for alcoholism, addictions, and other "anti-social" behavior.

As the paper's presenter, Dr. Judianne Densen-Gerber, put it: How often can we expect a female child, violated at three, four, or five years old by a man from whom she had every right to expect protection from sexual exploitation, develop into a coping, functioning member of society? And what can we expect of her children? (Many of the women studied had several, said Dr. Judianne Denser Gerber.)

Although more investigation is needed, to deny the potentially profound implications of this study in the etiology of alcoholism and addiction in women would be rash.

Troubled men and troubled women make troubled children together. To set women above men would be no more right than having neglected them. But to fail to give them equal time and attention is to fail the next generation.

—AM

A "slick" beginning

THE INTRODUCTION in Saskatchewan, Manitoba, and Ontario, of educational programs highlighting the risks of alcohol consumption shows a lot of faith in the persuasive power of the public media.

How effective the Ontario program will be in changing attitudes is still to be determined.

But if the media is at all effective in modifying social attitudes, this program should work since it has been crafted according to the highest professional and technical standards of the visual arts, television, radio and film. "Slick" is the word we normally use.

As was suggested at the Ontario program unveiling, "slick" is to many people a pejorative. "Multi media," and "commercial" mean playing to the gallery.

Well what's wrong with that?

In this case it is the gallery that counts and the gallery is accustomed to slick, sophisticated, commercial productions.

It's true the amounts spent in these programs are but fractions of what is spent by alcohol merchandising concerns, and competition for the viewers attention is fervent.

But a beginning has been made. Public money in sizeable amounts has been appropriated for the purpose of getting people to use alcohol more carefully, to drink less.

More than likely, the provincial programs won't make dramatic intrusions into public drinking practices. Not yet. It takes time for attitudes to change and it takes time for that change to work its way into the style of living.

But, a beginning has been made, it should be encouraged.

A closer reality

EMOTIONAL TRAUMA is routine these days. We get it in color with breakfast.

And as dutifully as Adler's rats salivated, we respond with the appropriate noises.

Resigned, we prefer our shocks giant-sized—wars, famine, corruption. And we are grateful when they are delivered, packaged, by our televisions and newspapers.

These are dangers in our responses to those distant disembodied stimuli. They allow for, perhaps encourage, an almost luxurious notion that reaction is compassion. And they threaten to overwhelm our capacity to be moved by closer realities.

Recently, a doctor was lecturing a group of medical students. The subject was child abuse, the message was real, and the doctor chose to illustrate with slides.

Outraged and indignant, the students raised a storm of protest, but not about the assaults on the children. The *slides* had offended them.

They had been confronted with a reality too close, too real.

One fears that the medical students, bright and presumably concerned, may not have been particularly unusual—as students or human beings. And one wonders how many of them, indeed how many people in the field of addictions, would find themselves as repulsed—by needle marks on a mother's arm, a father's drunken stupor, the smell of grinding poverty, or even a different lifestyle.

Defences against distant surrealism may now be an essential part of life. More reason why the capacity to be moved by one's own reality, must not be allowed to become an historical relic, an embarrassing memory.

—AM

"I envy him his tough day at the office – it's such a perfect excuse to get smashed... "

Letters to the Editor

Sir:

As I read **The Journal**, (April 1), I am appalled to note that at no time in any report of scientific research, or any write-up of addictive circumstances, is any suggestion made as to what might prevent individuals becoming addicts.

It is a well-known fact that the problem of alcoholism is at an all-time high. The one and only cause is ALCOHOL.

The educational program to teach "responsible drinking", which is now being instituted by some groups, will be an impossibility because each person will choose to be his own judge of "responsibleness".

The lowering of the legal drinking age, the opening of outlets, the lengthening of hours of sale, the leniency in granting so-called "special permits", have all contributed to the marked increase in sale and consumption of alcoholic beverages. This in turn has resulted in more crime, broken homes, and highway accidents. Alcohol has played a major part in the cause.

Is it not time that those studying the problem think of prevention rather than cure?

Mrs. Janet L. Armstrong
Editor, News Bulletin
Ontario Woman's Christian Temperance Union

'Brain damage'

Sir:

We are disturbed at the manner in which a recent research project was reported in **The Journal**, (March 1).

Under the headline "Animal experimentation indicates Marijuana produces brain damage" was the report of a recent study on rats injected with varying amounts of THC. Although it was stated that the series "provided a reasonable model for heavy drug use among humans", the figures provided were simply absurd.

To put aside the enormous dif-

The study's authors reply—page 12

ference in the neurophysiology of a rat and a human brain for the moment, the amount of THC ingested was simply enormous. Bearing in mind that the average marijuana cigarette weighs about 1.5 grams and contains marijuana of an average 2% potency, for a human to injest an equal amount of THC to obtain the 20mg THC/kg body weight, the poor unfortunate would have to boil down approximately 300 marijuana cigarettes and quaff the brew daily for at least a month. Since the 10 mg/kg. experiment (150 marijuana cigarette brew daily) produced negligible results, we must ask what Dr. Kalant's reasoning was.

It has been demonstrated that extracting the nicotine from less than ten cigarettes would be fatal. If one must poison rats with toxic doses of powerful chemicals, so be it. But to relate in any way this massive chemical trauma in a manner so totally unlike any human usage *to* human usage is utterly irresponsible, and most unlike the normal reportage of **The Journal.** The study was well done; the headline should have read "Rats stomach-fed with massive doses of an extract from marijuana exhibit mental dysfunction"

After checking our files, we note that that the only verifiable death due to marijuana injestion occurred in December, 1973.

On that date, Bruce McKenney, an 18-year-old student at Northern Illinois University, was found dead in his room. It was learned he had been distilling marijuana in alcohol and acetone, and had been drinking the resulting solution for some time.

Dr. Kalant might make use of this knowledge to forego any possible duplications of his tests in humans. You *can* kill a person with enough of anything, but apparently rats have a higher resistance to THC than humans.

Laurence O. Mckinney President
Cannabis Institute, Cambridge

MA

Backgrounder

By MILAN KORCOK

IN 1972, Canadian drug stores dispensed more than 91 million prescriptions to portions of this country's 20 million people.

That is well over four prescriptions for every man, woman, and child. And it does not include drugs dispensed in hospitals and other institutions.

That same year, each resident of the United States averaged 5.5 scripts via retail outlets.

Particularly significant in this scenario is the number of those pills and potions engineered to alter one's consciousness, to change one's mood.

Stimulants, major and minor tranquillizers, antidepressants, sedatives, and hyponotics make up a big piece of action for the drug industrial complex.

In 1971 Hoffman-LaRoche, whose products account for half of the world's sales of psychotropics, reported their sales had been increasing at the rate of 15% annually over the past few years.

It has been estimated recently that 22% of adult American men and 37% of adult women use some type of psychotherapeutic drug at least once a year.

And U.S. researchers (Stolley et al in 1972, and Hugh Parry and others in 1973) reported that almost 17% of all prescriptions written in U.S. drug stores are for psychotropics.

That calculation, as far as it goes, is remarkably similar to one reported by Addiction Research Foundation scientist Ruth Cooperstock who in 1974 claimed that 17.8% of all prescriptions in an Ontario sample were for psychotropics.

But Cooperstock took it one step further to show that even this 17% was a conservative estimate.

When she tallied preparations with "hidden" psychotropics, and added in central nervous system preparations, it appeared that 44% of all prescriptions dispensed contained some mood-modifying substances.

Within this broad range of psychotherapeutic drugs, the minor tranquillizers—particularly the benzodiazepines (such as Librium and Valium) make up more than 43% of all prescriptions. This is the largest single grouping.

If there is any overall pattern in the consumption of prescribed drugs over recent years, it is that there has been a gradual increase in use of all classes of psychotropics (hypnotics, stimulants, sedatives, antipsychotics and antidepressants). But use of anti-anxiety agents (primarily the minor tranquillizers) has more than doubled.

As Cooperstock notes: "Valium is by far the most popular individual drug in the United States, as elsewhere. One in 10 Americans 18 years of age and over had a prescription for Valium in 1973."

Given these facts, many people have characterized this psychotropic drug use as the signal of a stoned society. They have developed stereotypes and cliches, the most hackneyed of which is that the upper- and middle-class suburban housewife, bored with her lot and swallowing tranquillizers by the handful.

Not all of these cliches are justified.

Studies by researchers from the U.S. National Institute of Mental Health in collaboration with George Washington University, and the Institute for Research in Social Behaviour at Berkeley, show it is not the middle-class suburban woman who is the most common user of psychotropics but the poorer and less educated woman.

It appears the lower the social position, the more likely the housewife is to be a consistent psychotropic drug user.

As the studies show, better-educated and better-off women have fewer social pressures on them, more social options and releases, and are more capable of using drugs in a restrained and cautious manner.

The construction of stereotypes has proven to be a plague to an understanding of drug using patterns.

North Americans, for example, have been characterized as sliding to Hell on a cascade of pills. But several studies dispute the notion that they are any more prone to pharmaceutical excess than the citizens of other industrialized nations.

Cross-national data showed that the level of anti-anxiety sedative drug use in the United States would have fit right into the middle range of nine European countries in which measurements were done.

Parry-Balter data suggest some very clear trends of drug use in the U.S.:

- About 8% of Americans can be classified as high users (high is regular daily use of psychotropics for at least two months);
- About twice as many women as men fall into the high user category;
- People over 30 years old have twice the prevalence rate of high use as have people from 18 to 30 years;
- Residents of western states not only report higher prevalence rates for psychotherapeutics (on prescription or over the counter) they are also more likely to get their drugs through non-medical channels.

A pivotal factor in the use of psychotherapeutics is, of course, the physician. And how great the impact of physician restraint can be in this area is exemplified by Canada's experiment with the imposition of restrictions on amphetamines in 1973. (At this time, the federal government implemented a plan holding physicians accountable for prescribing of amphetamines for anything other than rigidly defined therapeutic criteria—not weight reduction.

Partly because of adverse publicity about physician prescribing abuses, but primarily because of the federal legislation, consumption of amphetamines dropped 90% within the first year after imposition of regulations.

The impact of physicians' prescribing practices on the dispersal of psychotropics is tremendous. But the origins of these practices are often shrouded in misconception. For example: the bulk of psychotherapeutic prescriptions are issued not by psychiatrists, but by general practitioners and internists.

In a Toronto study done by Cooperstock, general physicians wrote more than 70% of all prescriptions for psychotherapeutic drugs. In the Parry-Balter studies, psychiatrists and neurologists accounted for only about one third of the prescriptions for antidepressants and major tranquillizers—primarily for mental disorders.

In fact, 85% of the patients surveyed who had used psychotherapeutic drugs in the preceding year had never seen a psychiatrist professionally in their lives.

(Next month: The "walking wounded", polydrug users, the difficulty in their treatment.)

Guest Book

The bear went over the mountain
The bear went over the mountain.
The bear went over the mountain.
To see what he could see . . . .

We all know what the bear saw. And having turned the corner on drug abuse, we're not much better off than that fabled bear who could only see the other side of the mountain.

We can only surmise that the bear chose to climb his way over the obstacle rather than digging through. The song doesn't disclose the motive for the climb, but does reveal the consequences.

What the bear saw was not a result of poor vision, but of conditioning in the climb. And like the bear in mind, the drug abuse field has been similarly conditioned. The result for us has been limited visions and obstructed views. For example, at some point in the climb, all of us have been sidetracked at Rhetoric Gap or stopped off at Liberal View. For some reason we liked what we saw: "poverty, racism, unemployment, illiteracy, poor housing, and the lack of educational opportunities" as the causes of drug abuse. The other side of the mountain was all that we could see.

With this view, let's examine four groups on the slopes: Experimenters, Regulars, Down-Hill Racers, and the Retirees. Each with different causes, conflicting reasons, varying excuses.

The Experimenters: Hoards of them. Red and yellow, black and white. All unconspiring. Breeding curiosity. Responding to normal, appropriate, necessary and healthy instincts. For them, our litany of causes has been itself abusive.

The Regulars: When we see them do dope regularly, we know that they have to (a) do it to be liked, (b) be liked for doing it, (c) like it because they do it, (d) do it because they like it, (e) none of the above. The causes or justifications for regularity begin to get complicated. The Regulars don't fit the litany that didn't fit the Experimenters.

The Down-Hill Racers: The causes, the reasons dramatically change. The litany doesn't and we're trapped with an incidence and prevalence survey. (You see, the Trapper has a tracking grant from the Committee. The territory, of course, has been assigned by the Single State Ranger.) The questioning begins. The object: To confirm the litany. The Trapper knows what you, the Racer, know. And he knows you know he knows. But if you know what he knows, you know that he doesn't know what he told them he knew. So what is learned is that the other side of the mountain is all that they can see.

The Retirees: The results of the Racer survey are processed by the former racers as part of bear-trap training (camouflaged as credentialing). And the Committee ponders for days and weeks and months and four minutes the mysteries of the other side of the mountain. And since the Retirees want to get on the Committee, they see what they can see.

Viewing drug abuse this way has enabled us to (a) dodge the problem, (b) escape reality, (c) support the status quo, (d) spawn program mediocrity, (e) all of the above. We have conveniently linked our fate to a host of other social problems we have resolved unresolved. And entrenched in our self-styled security, we say that until all these other problems are solved, we shouldn't expect too much from our drug abuse efforts.

This focus blindfolds the planners and equips the system with another excuse for incompetence. Racism, impoverishment, elitism, and a false sense of security result or continue.

Unconscionably, we're locked into this vision. We can't see the options. The other side of the mountain is all that we can see.

But the options are there. For example, we can see drug abuse as a result of the isolation of the human spirit, loneliness, low self esteem, indifference, peer pressure, need for instant gratification, and too many mountains to climb. All of these issues are indifferent to race, environment, economic and social status. Whatever relationship exists between drug abuse and the list of social problems cannot be explained as causal. Drug abuse like other social problems is an independent barometer of the quality of human life.

If we can track where we've been we can start over. With new visions. In North American Indian folklore, the bear track is a "good omen." Our choices begin with (a) grin and bear it (b) prevent forest fires, (c) rocky mountain high, (d)_____. Now's the time to explore alternatives, and new horizons, and use the leverage we have with drug abuse.

(Peter Hammond is Director of Communications at SAODAP.)

CODA involved

Sir:

This will act as a mild objection to the rather offhand reference to the Council On Drug Abuse in the news item Drug Pamphlets in Pharmacies (**The Journal**, April 1, 1975).

It should be pointed out that CODA established the first health education centres in the two drug chains mentioned in the news item some five years ago.

This was in the form of a rotating metal unit in which six of the CODA brochures on drug abuse were displayed. These units have been constantly supplied up to late 1974 when both drug chains decided to enlarge their information centres to include other health items.

CODA has distributed more than 2,500,000 pamphlets, mainly through these outlets, from coast to coast, and weekly replenishes these centres upon request. You might say that the CODA pamphlets are the "best sellers" of these units.

However, we are pleased to see that the importance of these health information centres has been formally recognized.

E. A. Westendrop, President
Council on Drug Abuse

By Wayne Howell

THE GUINESS Book of World Records, the famous bible of trivia and esoterica freaks, very sensibly refuses to list any records involving the consumption of more than two litres of beer and absolutely refuses to list any records involving the consumption of liquor.*

However, a close perusal (a very close perusal—you may not find these records in the book at first reading or the second . . .) of The Guinness Book of World Records shows that there are a few world records of interest to those involved in the alcohol and drug field in Ontario.

For instance, there is: **The Most Hypocritical Hooker(s)**: In March of 1975 the provincial government of Ontario, Canada, announced a $3 million 3-year multi-media advertising campaign against the evils of alcohol abuse in the province.

Since the yearly anti-alcohol advertising budget represents 2.6% of the province's annual profits from the sale of alcoholic beverages ($266 million), this supercedes the previous record for hypocritical hooking which was held by Senora Maria Salanero of the Ramblas, Barcelona, who each year faithfully contributed 2.9% of her gross to research into the treatment of venereal disease.

The Worst 'Good news and Bad news' Joke in the World: Told by H. B. Twillingham of Cambridge, Ontario, Canada on April 17 of 1975—

'There's good news and bad news. The good news is that soon you will be able to order a drink of milk in an Ontario tavern'.

What's the bad news?'

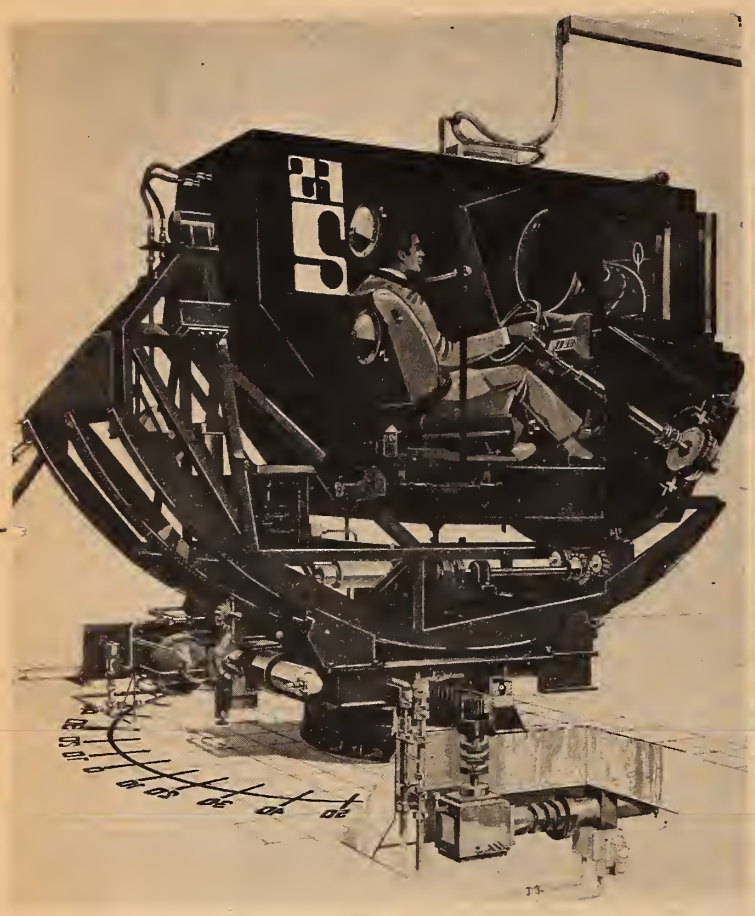
'They won't let you have any peanuts with it'

The Silliest Defence Against a Divorce Action: H. R. Wilburforce of Toronto, Canada, contested a divorce action brought against him by his estranged wife Edith on the grounds that his actions—the capricious censoring of his wife's entertainments, his secret disciplinary tribunals which resulted in withdrawl of privileges and which were not subject to appeal, and his high-handed and arrogant manner—were not examples of 'mental cruelty' as alleged by his spouse since he was only trying to respond, to the best of his ability, to a request in a government advertising campaign that he learn to become 'his own liquor control board'.

The Goofiest Film Script Ever Created: John W. Throcton-Boggs of Hamilton, Ontario, Canada, submitted to a Hollywood agent a film script so incredibly absurd, so silly, that neither Woody Allen nor Mel Brooks would consider it.

The proposed film dealt with the response of provincial authorities to a new law allowing young people to consume alcoholic beverages at age 18. When the authorities discovered that impaired driving charges against 18-to 21-year-olds increased by 900% in Toronto as a result of the legislation, they responded by sending police to a border town tavern where they looked into the rectums of young drinkers—for marijuana.

* There are no prohibitions against records for marijuana consumption but since none appear in The Guinness Book of World Records, this leads one to speculate that marijuana record-setters either tend to forget their achievements or lack the motivation to forward them to the Guinness head office.



Cutaway view of Volkswagen's driving simulator in which alcohol effects on motorists are tested.

World's most modern driving simulator

By JOHN DORNBERG

MUNICH—How little and how much alcohol in the blood stream does it really take before a motorist becomes a menace on the road?

The Volkswagen Company's research and development division recently sought a scientific answer to that controversial question in cooperation with Dr. Joachim Gerchow, a Frankfurt professor of forensic medicine.

The conclusion: Even at 0.05% blood alcohol content, a motorist's driving ability is seriously impaired. West Germany reduced the legal limit from 0.15 to 0.08% several years ago.

The tests were conducted with 12 drivers, chosen by lots from a panel of 1000, on the world's most modern and sophisticated driving simulator at the Volkswagen Co.'s R-and-D laboratory in Wolfsburg.

A totally computerized and hydraulically operated rig, it can simulate virtually all road conditions and situations and records driver reaction electronically.

Each of the 12 subjects had to participate in 11 drives without alcohol, 10 with a 0.05% content and four with a 0.08% content over the three-mile simulated course during a period of three days.

The texts showed that even a 0.05% blood alcohol content stimulates faster driving and at 0.08% the average motorist tends to drive 15% faster than when completely sober.

Weaving and a tendency to go off the road's right side was so pronounced at 0.05% that eight of the 12 test drivers would have caused serious accidents while at 0.08% several went off the road completely.

The tendency to go to the left was equally pronounced, although two of the 12 drove without mistake and two more tended to veer to the left more sharply at 0.05 than with a 0.08% blood alcohol content.

One of the test drivers veered 15 feet to the left for 3.6 second at 0.05% and for 9.1 seconds at 0.08%.

Reaction-time and coordination ability, according to the test series, also tend to deteriorate markedly under the influence of relatively small amounts of alcohol.

Coordination ability decreased by 7% at 0.05 and by almost 12% at 0.08%. Among some of the test drivers the simulator recorded deviations of up to 20%.

At 0.08% the reaction time of some of the drivers increased by more than 40% over their sober state.

Peripheral vision was also tested and at 0.05% was noticeably impaired in two of the 12 drivers. At 0.08%, nearly half of them displayed signs of so-called "tunnel vision" which is regarded as a major factor in alcohol-related accidents.

The Wolfsburg simulator recreates daylight as well as nighttime conditions via a television screen. The cabin, replete with steering wheel, gear shifts, brake, clutch and gas pedals, fully-operable dashboard, windshield, wipers and safety belts, is mounted on a hydraulic lift that simulates rough-road, varying highway crown and shoulder situations concurrently with the television picture.

The test results have been made available to the West German Transport Ministry for use in its current anti-alcohol campaign.

Crime 'pays' in Australia . . .

CANBERRA —Organized crime is good for the economy, according to William Clifford, director of the Australian Institute of Criminology.

"We would be myopic indeed if we did not recognize the economic benefits of the operations of successful criminals—especially organized criminals with bloated intakes from gambling, prostitution and drugs," he told a recent conference on the economic consequences of crime.

"This money has to find an outlet and we cannot possibly overlook the benefits which accrue from investing it in legitimate business."

Mr. Clifford, former head of the United Nations crime prevention and criminal justice services, also pointed out fighting crime keeps a whole security industry involving locks, alarms, guard dogs, and guards in business, and provides employment for thousands of policemen, judges, court officials, probation officers, child care workers and researchers.

As far as economics are concerned, morals are only part of the picture, he said: "You must remember that Robin Hood was not just a robber, but someone who redistributed wealth by taking from the rich and giving to the poor."

Nevertheless, he predicts society will ultimately have to make a cost-benefit choice between the morally excessive cost of recycling "criminal" dollars and the increasing sacrifices required to fight an ever-rising crime rate.

The difficulties will be compounded by the lack of research into the amount of crime society is prepared to accept, how much more it wants to spend preventing such crimes as drunkenness, etc., and by factors such as five dollar muggers having higher criminal profiles than companies making five million dollar profits through false packaging, he said.

. . . but pushers beware

CANBERRA—Australian drug pushers may soon face increasingly severe penalties, while users receive treatment rather than punishment.

Speaking on a new current affairs television program, Australian Minister of Health, Dr. Doug Everingham, described existing penalties for drug trafficking in Australia as "laughable".

"They would be crippling to an individual, but to a really big organization it's just part of their ordinary business expenses," he said. "Some of these pushers are very big people and to deter them you've got to have big penalties."

Importation, availability, and consumption of drugs, have continued to increase in Australia as in most other countries, mainly "because there's money in it, because the community is generally more affluent, and because more people are involved".

However, the federal government aims to eliminate drug trafficking and will increase police surveillance and other methods of prevention as necessary, he said.

Differentiating between marijuana and other drugs, such as heroin, Dr. Everingham suggested penalties could be lowered for use of some drugs, and also for use as distinct from pushing.

He proposed first offenders, and some second offenders, be sent to treatment centres rather than jails, and called for a general change of emphasis from drug use per se to the underlying social problems.

"Most of these so-called drug problems are, in fact, people problems . . . if people didn't have problems they wouldn't turn to drugs."

Long-term treatment ineffective in alcoholism

By JOHN DORNBERG

DUESSELDORF — Long-term drying-out treatment of alcoholics is not only ineffective but intolerably expensive, a prominent West German researcher insisted at a symposium here recently.

Moreover, said Dr. Thomas Zickgraf, head of the mental hygiene division of the German Medical Association, it tends to have a penal and deterrent character.

Although West German courts, welfare agencies and temperance societies are advocating long-term treatment courses, Dr. Zickgraf regards them as "not very beneficial."

Keeping alcoholics locked up for six months and longer, he said, does not usually lead to success and costs the quasi-governmental health insurance companies DM 20,000 per patient.

Hospital treatment lasting six weeks, backed up by modern outpatient treatment, however, results in a 50% cure rate.

German temperance movements, he said, had been making a mistake for the past century by only taking care of and looking after alcoholics who had been given at least six months' treatment. "There is no scientific evidence for the correctness of their approach," he contended.

Wolfgang Glahn, secretary of the German Psychosomatic Therapy Association, speaking at the same symposium, described alcoholism as the "number one socio-medical problem in the Federal Republic today."

According to Glahn there are 900,000 known alcoholics and an additional 600,000 "unregistered cases."

(Federal government statistics refer to 600,000 known alcoholics plus 600,000 additional "problem drinkers.")

Alcoholism, he said, costs DM 6 billion in lost productivity annually, not to mention the expense of its treatment.

A shortage of 20,000 hospital beds and 10,000 staff, Glahn said, precludes even effective short-term treatment of alcoholics. He called for the establishment of a network of institutions specializing in the treatment of psychosomatic diseases, of which, at present there are only two with a total capacity of 300 beds.

For French smokers

A 5-day way to quit

PARIS—A survey of people who followed a 5-day plan to quit smoking has shown that about 40% of them were still not smoking 12 months later, a group of French doctors was told here.

The doctors were attending a session on smoking held during the Entretiens de Bichat, the annual medical meetings for general practitioners in France.

The large attendance at the session, as well as the absence of cigarette smoke, was considered a landmark by anti-smoking forces in a country just becoming aware that smoking is dangerous.

The free five-day plans, conducted by the Life and Health League, which is affiliated with the Seventh-Day Adventist Church, are the only widespread programs here to help people stop smoking. They were introduced in France in 1965, and since that time approximately 50,000 persons are estimated to have participated.

Philip Augendre, who edits the League's publication, said that about 80%-85% of people who start the plan are able to stop smoking at the end of the five days, and that at least one follow-up survey showed 40% at the end of one year.

The five-day plan is the work of E. J. Folkenberg and Dr. Wayne McFarland. Rev. R. Jublin explained in an interview following the session. It consists of an informational meeting followed by five 90-minute sessions on five consecutive days.

During the 5 days, Mr. Jublin explained, participants are encouraged to abstain also from all alcoholic beverages, from stimulants such as tea and coffee.

Around the world

Psychotropic drugs are being dumped in Africa, often disguised, African delegates to the United Nations Narcotics Commission have reported. Dr. Faadji Johnson Dagbegnikin of Togo's health department, has appealed for tighter registration and controls.

* * *

A Swedish research team says cigar smokers run a greater risk of lung cancer than cigarette smokers and warn pipe puffers they aren't much better off. The group at Stockholm's Karolinska Institute said the study showed "the risks for getting lung cancer from cigar smoking are even higher than cigarette smoking."

* * *

East African Airways is increasing its efforts against employees involved in smuggling narcotics. Several airline employees have been charged with smuggling marijuana from Kenya to Britain. Director-general has asked flight crew and cabin staff for assistance in reporting any members suspected of trafficking.

* * *

Father McVernon:

'Religious trips too often deteriorate'

By TOM HILL

BROOKLYN, NEW YORK—The religious counsellor *can* play a constructive role in "the drug scene".

However, it is important that he approach the role modestly and with proper understanding, says Rev. John J. McVernon, a Roman Catholic priest who has been working with drug-using young people for more than a decade.

"Too often a religious trip deteriorates into a sentimental kind of surface faith that doesn't last and leaves the person as burnt out and disenchanted with religion as he may have been with drugs. You can't hide from life in God. If you could, we wouldn't have the sixth graders smashed on methadone in the Williamsburg section of Brooklyn, or the multi-million dollar amphetamine ring in Phoenix, or nine million people wrecked by alcohol in this country.

"Laying a sermon on the head of everyone who comes into the chaplain's office won't turn that head around. But a little patience and a little reality and a lot of love and no handouts might do the trick."

The fundamental insight for clergymen working with drug-dependent people is to realize they are just like everyone else except they use a lot more drugs. "And even that distinction isn't always valid," says Father McVernon.

Chaplain of the New York State Drug Abuse Commission, the Brooklyn priest serves two state institutions for the mandatory treatment of drug users. His congregation represents that segment of the drug-using population least amenable to treatment.

Father McVernon does not use the term "addict" or "junkie" or "dope fiend" to identify the people with whom he works.

"Whatever an addict, or junkie, or dope fiend is, those labels do not adequately describe all that they are. They are people first—men and women, parents, children, lovers, loners, workers or goof-offs. Just as with any other congregation, we must live with them and work with them as they are.

"We have to be careful too, to avoid hiding behind labels ourselves—like 'ex-addict,' or 'straight' or 'cleric'. Our title, even our garb, can protect us from reality just as drugs protect others. . . . . If we expect our people to live, we have to be willing to live with them."

Father McVernon says it is a mistake to imagine that to be effective with people deeply involved with drugs, you have to dress like them, get high with them and use their language.

"You generate a great deal of despair in those whose lives are coming apart with drugs if your life is no different from theirs. They want to have hope that there is something better than the turmoil they find themselves embroiled in."

Some religious counsellors may be turned away from contact with drug addicts because of publicity describing addicts as "violent and manipulative".

While the person on the street can be extremely violent "in his hustle to get the fix," says Father McVernon, the drug user in low

Rev. John McVernon

key conversation with a religious figure is quiet and non-violent.

"He's lonely and if you come off as a non-threatening, non-punishing, open individual, he won't turn you off. He has too few friends to squander any."

Is the addict manipulative? "Yes, about on a par with a pastor who has to con his people for a more generous contribution when the basket comes around."

But fear is not the only reason a clergyman may avoid the heavy drug user. Often there's a feeling of inadequacy. As Father McVernon puts it:

"We've been taken in by the mystique that surrounds the drug scene—an aura created by drug experts, suggesting that some rare skills must be acquired and some hidden knowledge unearthed in order to be effective with drug users. The truth is that the same skills and same knowledge that make you competent to help any problemed person will enable you to aid a person whose problem happens to be drugs."

Although religious programs to combat drug addiction have been hailed enthusiastically, Father McVernon does not regard them as always effective.

"I know Teen Challenge has impressive statistics and the Muslim and the Hassidim have met with success. Thank God for those miracles of grace. But it doesn't work for everybody."

Discussing his own work, Father McVernon said the commission is responsible for the care of people who have been committed by the court as wards of the state because of drug usage. It cares for these persons for from three to five years.

"Our statistics do not describe an experience of unalloyed success. Most often our efforts don't work.

"But then, what intervention program—if it's honest about its dropout rate and complete in its followup—can point to dazzling success? Like most efforts, our attempt helps maybe 5% of the addict population to reach the taxpayers' definition of success—no crime, no illegal drugs, no welfare."

UK health minister angered by cigarette industry

By ALAN MASSAM

LONDON—The British cigarette manufacturing industry is coming under increasing pressure to restrict its advertising and promotion and to make a substantial contribution towards health education.

And Minister of State for Health, Dr David Owen, has revealed in a House of Commons statement that he is very angry indeed about the industry's refusal to co-operate.

Dr Owen said he made detailed proposals to the industry last July seeking "voluntary agreement to new measures designed to bring home to the public the very serious dangers to health of cigarette smoking."

The proposals included:

1 That the industry should give a sizeable percentage of its total expenditure on promotion towards financing public education on the health hazards of smoking;

2 That the advertising of cigarettes in cinemas should be abolished;

3 That tighter control be exercised over the way sponsored events are used by manufacturers to promote their products;

4 That discussions between industry and the department of health on the display of tar yields on individual brand packets of cigarettes should reach a speedy conclusion;

5 That the present health warning on cigarette packets (Government Warning: Smoking may damage your health) should be changed to read DANGER: CIGARETTES CAUSE LUNG CANCER BRONCHITIS, HEART DISEASE, and that it should be transferred from the side to the flap where it would be seen more easily;

6 That gift coupons ("credit notes" included in some cigarette brand packets which can be collected and exchanged for goods) should be abolished or limited to brands with low or low-to-middle tar yields.

Dr Owen told the House of Commons (in answer to an MP's question) "It is a matter of great regret to me and, I think, to all who are concerned about the real dangers to health which come from smoking, which currently accounts for at least 50,000 premature deaths a year (in Britain), that the industry was not able to agree to any of these proposals."

On his key proposal (that manufacturers should put large sums of money into health education) Dr Owen said the industry would not reveal to the department of health how much it spent on promotion.

The department estimated, however, that in 1974-75 the industry's expenditure on press, poster and cinema advertising in the United Kingdom would be about £15½ million ($37,665,000); on sponsorship between £2 and £4 million ($5 million and $10 million); and on gift coupons about £50 million ($121 million).

The total figure for promotion in 1974-75 would probably therefore be around £70 million ($170 million). Health education spending at a national level on smoking in the United Kingdom was £330,000 ($802,000).

Dr Owen's one success so far in his campaign was to persuade the industry to submit its cigarette advertising to a code of practice laid down by the Advertising Standards Authority (an independent body).

The code is expected to take effect soon (probably this month) and will be aimed at preventing cigarette companies from associating their products with a healthy aura and suggestions that they might bring sexual, social or financial success.

Mr Peter Thompson, director of ASA, stressed, however, that the code was only likely to affect a few brand advertisements and was not, as some critics of the tobacco industry have suggested, the first step towards a total ban on cigarette advertising.

"The Advertising Standards Authority is not in the business of doing the Government's job for it," he said. "If they want a ban on cigarette advertising then they must shoulder the odious task of doing it."

The total ban on cigarette advertising (at present such advertisements are only banned from Britain's television screens) is the objective of many doctors and health educators, however.

One Welsh family physician, Dr Alistair Wilson for example, is organising a lobby of doctors to press their MPs for a ban on cigarette advertising. Sir Cyril Clarke, president of the Royal College of Physicians is understood to have expressed his support.

Dr Wilson is also forming a Welsh branch of the Royal College of Physicians pressure group, Action on Smoking and Health, whose director, Mike Daube, says he would like to see a total ban on the advertising of all tobacco products enforced by law. He said of Dr Wilson's efforts: "We believe that a lobby by doctors later in the year could have a greater effect on public opinion than any efforts by a charity."

Cancer not a death sentence

LONDON—Cancer of the bronchus causes more than 30,000 deaths annually in England and Wales and many authorities consider prevention the leading hope of reducing the mortality.

This was acknowledged recently by Lord Brock, former president of the Royal College of Surgeons, who reviewed his experience of lung cancer surgery in the British Journal of Surgery.

He said although most cases do badly even when the lesion appears to be resectable at operation, the diagnosis need not necessarily be regarded as a death sentence.

Lord Brock gave details of 13 patients who had lived more than 20 years after surgery, but he was going back over 35 years of experience. He mentioned that nine patients apparently successfully treated for their original tumour subsequently developed a second lung cancer. *Five of them had failed to give up smoking.*

Polish drug study

8% of teenagers have experimented

MUNICH—More than 8% of teenage Polish school pupils have experimented at least once with drugs or narcotics.

This is the conclusion of an extensive survey conducted by a group of Polish sociologists in the high schools and vocational schools of the tri-city area of Gdansk, Gdynia and Sopot on the Baltic Sea coast.

Results of the survey, conducted in 1972, were published in the most recent (December 1974) issue of *Sociological Studies*, a quarterly of the Polish Academy of Sciences.

The researchers queried a cross-section of 15- to 19-year-old students in the tri-city area which has a population of 660,000. They concluded that 8.3% had tried drugs at least once, although they surmise, from the high number of questionnaires that remained unanswered, that the percentage may be even higher.

The survey did not illuminate what kind of drugs were being used, but other Polish sources have previously called attention to the widespread use among teenagers of TRI—or trichlorethylene—a cleaning fluid that is readily available and produces an intoxicating effect when inhaled.

Marijuana, hashish, LSD and opium-based narcotics are reportedly also in use but not as prevalently.

According to the survey, drug usage and experimentation are more prevalent among boys (11%) than girls (about 6%).

Up to age 16, only 5.7% have been exposed. In the 17- and 18-year-old group, use and experimentation reaches 9.2%. It then declines again to 7.8% among those aged 19.

The survey also disclosed a corollary between drug use and alcohol consumption and smoking. Among students who admitted they smoke regularly, the drug figure was 18.3%.

....More letters

"Pot produces brain damage"

Sir:

Referring to Milan Korcok's article "Marijuana produces brain damage" (**The Journal**, March 1), I would like to ask a few questions:

1) What's the point of doing a research about behavioural response to cannabis-taking in rats, while this research has been already done in humans (Zinberg-Weil, etc.)?

2) How can Dr. Kalant define as "a reasonable model for heavy drug use in humans", doses of 10 mg or 20 mg THC/kg, corresponding to 700 or 1400 mg in an adult human being, while the average social dose is 6.2 mg (Le Dain Cannabis Report 1972, page 34)?

3) How can one shift from THC effects to cannabis effects, from behavioural change to organic brain damage, and finally from brain damage in rats to brain damage in humans, which is the obvious implication of the article's title?

Giancarlo Arnao
Freedom and Drugs Committee
Roma, Italia

Sir:

I was dismayed to see a marijuana research article (**The Journal** March 7) headlined "Marijuana Produces Brain Damage". The principle researcher, Dr. Harold Kalant, "defines brain damage in terms of functional impairment instead of in terms of cellular damage".

The article in this case did not support the headline and misled me as a reader. First there was no histological confirmation; no cellular damage was found. Second, the speculation that maze errors after a three month break from the drug could only be the result of brain damage (accelerated aging) hardly seems conclusive. The dose of 20 mg/kg for 6 mo. in a rat is equivalant to 75 joints a day, *totally* consumed for 12 years by a human. Such an experience would certainly change the way the subject reacted to a learning situation with or without brain damage. I can't imagine any psychoactive compound used in that magnitude over such an extended period that wouldn't show major changes in behavior afterward.

Henry H. James
Drug Education Coordinator
Gryphon Place
Kalamazoo, Michigan

Authors' reply

Dr. Harold Kalant and **Mrs. Kevin Fehr**, co-author of the study referred to, clarify:

"The correspondents have fallen into the 'dosage trap' that lies in wait for people who are ignorant of pharmacology.

"They have taken our THC doses of 10 and 20 mg/kg in the rat, multiplied by 70 for the average human weighing 70 kg and concluded that the amount is 'absurd' because it corresponds to a dose of 700-1400 mg in man. The first point of which they are obviously unaware is that, over a wide range of species and drugs, sensitivity to drugs is inversely related to body size and surface area. A mouse needs five to 10 times as much alcohol, barbiturate, morphine, or any other drug acting on the brain, as a man does to produce the same degree of effect.

"For example, the rat requires a THC dose of 1-2 mg/kg intravenously to produce consistent reproducible effects on the EEG and on relatively sensitive tests of behavior, such as discriminated Sidman avoidance. Such doses have no effect at all on the rat's motor coordination, while the same dose smoked by man would produce gross incoordination, hallucinations and possibly an acute psychotic episode.

"The same is true of alcohol. We can not help wondering why your correspondents did not extrapolate our 6 g/kg dose of alcohol from the rat to man, as they did with THC. Had they done so, they would have found that it comes to 420 grams for a 70 kg man, or about 1250 ml of whisky taken all at once. This would be fatal in man, yet in the rat it causes only a moderately severe intoxication, which our animals were able to withstand daily for six months.

"The second point is that an oral dose of THC has to be *at least* three times as large as an inhaled or an intravenous dose to produce the same intensity of effect. This is true in all species, because it depends on the fact that absorption from the lung is much more rapid than from the intestine. On this basis, a dose of 10 mg/kg by mouth is only about two to three times the smallest intravenous dose needed to produce a reliable effect on the rat's behavior, while 20 mg/kg is about 5-6 times. The average social dose in man, producing a detectable effect on behavior, is about 6-7 mg, and 5-6 times this amount would be 30-40 mg. There are a number of clinical studies indicating that heavy regular users may smoke 50-150 mg or more of THC daily. The experiment was not intended to mimic light or moderate use of marijuana by humans, but *heavy regular* use; it did so. The fact is that the animals were visibly intoxicated for only about 4 to 5 hours a day. They ate well, gained weight, and remained in good general health, except for their impaired learning ability.

"As for the relevance of findings in the rat brain to the human: It may come as a shock to many humans, but their brains are not so different from that of the rat as they might wish. Of course the human brain is vastly more sophisticated, but the basic functions are essentially the same. The rat brain is also capable of receiving and recognizing information from the environment, reacting emotionally, making choices, gauging time, solving problems, learning, remembering and forgetting. Indeed, the resemblances are sufficiently clear that new drugs are always screened on rats and other animals at an early stage of investigation, to provide an indication of the kinds of effect for which they may be useful in man.

"Similar research *has not* been, and *can not* be, done in humans. The study by Weil, Zinberg and Nelsen dealt only with acute effects of a single small dose. This study dealt with the damaging effects of large daily doses over a long period of time. Ethical reasons obviously preclude such an experiment in man.

"Cannabis is a substance which provokes more reactions based on emotion or ideology than on reason. Terms such as 'absurd' and 'utterly irresponsible' often boomerang on their user if he is ignorant of basic scientific knowledge. One must wonder if it is not 'irresponsible' to make accusations or criticisms in an area clearly outside one's competence."

Smoking after heart attacks places men in jeopardy: study

MARCO ISLAND, FLA.—Men who have already had one or more heart attacks are greatly increasing their chances of dying if they continue to smoke.

This fact clearly emerged as one aspect of a giant clinical study of risk factors and the use of lipid-lowering drugs in 8,430 men aged 38 to 64 years in 53 clinical centers across the United States. Each man was involved in the study for at least five years, and many for six or seven.

In an exclusive interview with **The Journal**, the head of the steering committee for the study emphasized: "Cigarette smoking is still predictive of mortality after one or more infarctions, just as it is predictive of those who will suffer an initial heart attack."

Dr. Jeremiah Stamler continued: "In this study we took a history from each man which essentially was whether he smoked cigarettes or not. Those smoking at entry into our study had about a 40% to 50% higher mortality rate at five years as compared to those not smoking at entry."

Those "not smoking at entry" included both men who had never smoked, as well as a large number of ex-smokers, which seemed to confirm the advantage of quitting even by men who had smoked for a number of years.

"The effects were also found to be additive, with regard to cigarette smoking" said Dr. Stamler, a world-famous heart disease epidemiologist and chairman of the department of community health and preventive medicine at Northwestern University.

"The existence of high cholesterol levels and smoking was worse than the existence of either factor alone. There also seemed to be an adverse effect from lack of exercise, along with high cholesterol levels and cigarette smoking. So if you compare men active at leisure with those who were not, and men who did not smoke as compared with those who did, and then compared high versus low cholesterol levels, you got an additive effect. If you compared men with none of these risk factors versus men with any two or all three of these risk factors, the risk for the adverse group was 2.5 times higher."

The conclusions from this study, Dr. Stamler stressed, were that "every means should be employed by physicians and others to get people to quit smoking, and preferably BEFORE they've suffered their first heart attack.

"The big lesson from this study is that the key to this disease lies in primary prevention, in the years before the first event (the first heart attack) happens. And that lesson is underscored by the fact that this first event is fatal in one-third of all cases, and that most of these deaths are sudden deaths. So the approach to this disease is primary prevention by elimination of risk factors such as smoking, if we are ever going to stem the coronary disease epidemic."

The study in which Dr. Stamler was involved was sponsored by the National Heart and Lung Institute to evaluate the efficacy of high and low-dose estrogen, dextothyroxine, clofibrate and nicotinic acid as a means of lowering blood lipids (fats) in men who had suffered one or more heart attacks, and to determine the "natural history" of the disease.

Methadone overdose deaths related to intravenous use

SAN FRANCISCO, CAL.—A daily maintenance dose of 80 mg. - 120 mg. methadone is safe when taken orally but may be fatal if injected intravenously, according to a report from the University of Wisconsin.

Khalil A. Khavari of the university's Midwest Institute on Drug Use told the North American Congress on Alcohol and Drug Problems that methadone overdose deaths "may be, in part, due to people's underestimation of the lethality of methadone oral dosage when diverted to intravenous injections."

He said rats showed a massive and rapid tolerance to oral methadone but virtually no tolerance when the drug was injected.

Consequently, massive oral doses of methadone could be tolerated, but the same was not true of the injected drug, he said.

He suggested the studies might clarify the mechanism of methadone overdose deaths due to injection.

Such deaths, he said, are due to respiratory failure as methadone overdose by injection leads to both a sudden severe depression of bulbar respiratory centres and to neural blocking which may interfere with the action of the diaphragm.

The slower absorption rate from the gastrointestinal tract of oral methadone may allow for effective metabolism of the drug in the liver and minimize the effects on the respiratory system, he observed.

He suggested the development of tolerance to massive doses of oral methadone by rats, raised some questions about clinical use of methadone.

Once the daily maintenance dose is established, usually 80 mg. to 120 mg. in a few weeks, it is kept at the same level even when the patient is on the narcotic for years, he said.

But, the studies suggest "it is most unlikely that the initial maintenance dosage produces equipotent pharmacological effects over long periods".

If this is true, the patient "may be using the free daily 'fix' as a base which is augmented by anything else he can get his hands on—heroin, morphine, cocaine, amphetamines, alcohol, barbiturates, etc.," he suggested.

Short-term detoxification should not be written off

By LACHLAN MacQUARRIE

BANGKOK—Although most communities have rejected short term, ambulatory detoxification for heroin addicts, it offers a safe and inexpensive treatment which can attract large numbers of otherwise unreachable addicts.

This was the message of Dr. Robert Newman, assistant commissioner of addiction programs for the New York City department of health, to the 31st International Congress on Alcoholism and Drug Dependence here.

Dr. Newman said reluctance to consider short term detoxification springs from a widespread reluctance in the addiction treatment field to settle for anything less than a total "cure".

"This reluctance persists despite the notoriously chronic and recidivist nature of the condition", he said.

Yet, "short-term ambulatory detoxification has proven itself effective in attracting a substantial proportion of the narcotic addict population. It is also among the cheapest of all addiction treatment modalities, since a limited number of clinical facilities and staff can treat a large number of patients".

Dr. Newman acknowledged that sustained abstinence is an unrealistic goal for a detoxification program which has contact with addicts for a limited period of time. But, he pointed to a number of short term goals which this method can achieve.

"It can enable addicts to lower their tolerance and dependence on opiates, if only temporarily; it can identify and in many cases resolve acute medical and social crises which exist; it can act as a buffer to the vagaries of the illicit drug market, and prevent the 'panic' which is otherwise associated with temporary shortages of supply; and it can provide an orientation, and facilitate referral, to long-term treatment programs which are available."

Of major significance is the usefulness of this kind of program in attracting the otherwise unreachable addict. According to Dr. Newman, each new applicant for treatment provides additional evidence of the need for the program; and the program's role takes on increased significance because many of those who request detoxification have not previously sought other forms of treatment.

The New York City Ambulatory Detoxification Program was initiated in the summer of 1971. To be eligible, an applicant must be 18 years of age or older, have a history of current narcotic dependence, and not have been in treatment in the program in the previous 28 days.

Methadone is administered in dissolved form, with an inflexible upper dosage limit of 40 mg per day. No take-home medication is provided and, whenever possible, methadone administration begins on the day of application. The maximum duration of treatment is 14 days.

Dr. Newman said there have been more than 60,000 admissions since the program began. The average stay is slightly more than seven days.

In the first year of operation, approximately half of all patients admitted had never before been enrolled in any treatment program. The overwhelming majority of addicts contacted by other outreach programs accepted referral to the Ambulatory Detoxification Program while rejecting long-term modalities.

Admission process includes a physical examination, laboratory screening tests and a detailed social history. Every effort is made to refer the patient for appropriate diagnostic and therapeutic care, including counselling for non-medical problems. Special emphasis has been placed on creating an awareness among patients of the long-term treatment programs which are available.

Dr. Newman said about half of the people who entered the New York City program have returned for repeat detoxification. However, he stressed that this "revolving door" phenomenon should not be considered an indicator of failure.

"Rather, it is evidence that the patients perceive the services offered as beneficial".

"Very few cities", Dr. Newman said, "have established ambulatory detoxification programs as a distinct treatment entity. In New York City, where a massive ambulatory detoxification program has been in operation for over three years, its effectiveness has been clearly demonstrated—in large part by the sheer number of addicts who have voluntarily sought admission.

"In order for similar programs to be implemented elsewhere, it is necessary to recognise the special, short term objectives which are applicable in this modality, and to accept the relevance of this form of treatment to the addict population and the general community."

Alcoholics helping others leads to positive outcome

By MARY HAGER

SAN FRANCISCO, CAL.—Involvement of the alcoholic in the planning, delivery and evaluation of services for other alcoholics has proved a successful component of a community program in Taunton, Mass.

Stephen K. Valle, executive director of the Greater Taunton Council on Alcoholism, says it has been "extremely gratifying to witness the change from passive and withdrawn consumers (alcoholics) to people who assert themselves and demonstrate increasing self-confidence as they realize their own worth".

At the recent North American Congress on Alcohol and Drug Problems here, he described a program in which the services "are not viewed as an end in themselves, but rather as a means for the consumer to become involved in helping others with similar problems."

For example, the alcoholic who visits the centre's drop-in lounge in the evening recognizes that "consumers like himself" are staffing the lounge.

Once he realizes others with problems are making a contribution, the alcoholic recognizes he too can make a contribution. This can be "a crucial factor in rebuilding the damaged self-concept prevalent among those affected by alcoholism," said Mr. Valle.

The centre has two paid staff members, one professional and one para-professional. Thus, the consumer's services, whether in maintenance, reception or managing, become "an integral part of the total program".

As consumers become involved, they may, with training, assist in providing direct services to other alcoholics and, eventually, may join the centre's Advocacy Board which plans, evaluates, and implements changes in the program.

The experience of the alcoholics, combined with the expertise of the professionals, provides "a unique combination and increases the potential for meeting diverse client needs," Valle noted.

Problem solving teams are one example of successful integration, he said, as a recovered alcoholic may serve on the same team as a psychologist from the mental health program.

In such situations, "the professional often gains an appreciation for the natural ability of a recovered alcoholic to identify accurately with the client, and the recovered alcoholic often learns to appreciate the skills of the professional in facilitating client self-exploration."

The process is not without problems, warned Valle. The professional must be aware that helpers may become overzealous. Consumers may be insensitive to the role of the professional and may also overextend themselves to the point of failure, a possibility which the professional must recognize.

Finally, Valle cautioned, the professional may resist consumer involvement: He may be unable to handle the threat of an untrained person's providing services or he may underestimate the value of the contribution the consumer can make.

Success of such a program requires professionals skilled at supervision and training, who are not "threatened by the ability of others less trained than themselves, and who have an unwavering belief in the concept of consumers as people capable of making significant contributions for themselves and others," he said.

Book Report

The following books have recently been acquired by the Addiction Research Foundation library in Toronto. These books are not for sale at the library, but general enquiries may be directed to The Library, 33 Russell Street, Toronto, Ont. M5S 2S1 (595-6144).

Medical Lollypop, Junkie Insulin, or What?: Moffett, Arthur D., Adler, Freda, Glaser, Frederick B., and Horvitz, Diana. Dorrance and Company, Philadelphia, 1974, 82p.

A Systems Approach to Drug Treatment: Adler, Freda, Moffett, Arthur D., Glaser, Frederick B., Ball, John C., and Horvitz, Diana. Dorrance and Company, Philadelphia, 1974, 328p.

Sociological Aspects of Drug Dependence: Winick, Charles (ed.) CRC Press, Inc., Cleveland, 1974, 327p., $41.95.

A Model Act for the Rehabilitation of Chemically Dependent Persons: Minnesota Chemical Dependency Association, Minneapolis, 1974, 22p.

Drug Use Among Vancouver Secondary School Students: 1970 and 1974: Russell, John S., and Hollander, Marcus J. Narcotic Addiction Foundation of British Columbia, Vancouver, 1974, 183p.

The Problem Drinker: A Management Guide: Industrial Accident Prevention Association of Ontario, Toronto, 1974, 31p.

Drug Abuse and the Criminal Justice System: A Survey of New Approaches in Treatment and Rehabilitation: U.S. Department of Justice, Washington, 1974, 221p.

Drug Abuse and the Criminal Justice System: A Summary Report: A New Life For You. U.S. Department of Justice, Washington, 1974, 29p.

Runaway House: A Youth-Run Service Project: Butler, Dodie, Reiner, Joe and Treanor, Bill. U.S. Government Printing Office, Washington, 1974, 68p.

LCBO restricts alcohol advertising

TORONTO—Advertising of alcohol beverages has been cut back on both radio and television stations in Ontario, in accordance with a new set of directives issued by the Liquor Control Board.

The revisions, which went into effect March 1, 1975, restrict each winery, brewery and distillery to sponsoring no more than two hours of radio programming and 1½ hours of television programming per station per week.

The previous regulations allowed three hours of radio and three hours of television each.

There is some flexibility in the time allotments to permit sponsors of certain cultural or sporting events to cover the full events. But in no case are they allowed to exceed a maximum of 52 hours, per station, of radio or television program sponsorship, over the course of one year. This is a reduction from 78 total hours under the previous directives.

Regulations in respect to the print media remain unchanged.

Daily newspapers, for example, are restricted to a maximum of 1,250 lines per individual ad, a maximum of 4,000 lines per company per week, and a maximum of 78,000 lines per company per any calendar year.

It was reported by R. J. Harris, LCBO deputy chief commissioner, that none of the alcohol beverage companies resisted the reductions in radio and television exposure. They all accepted the changes without criticism "because they knew it was coming anyway," said Harris.

In Ontario, liquor advertising must receive preclearance by the LCBO. Ads placed without this preclearance can subject the manufacturer to charges. This has not yet occurred, say LCBO spokesmen.

The directives governing the frequency, size, physical location, even the content matter are precise.

The LCBO directs, for example, that in the interior of international airports and railway stations "a maximum size of one transparency per company on any level shall appear and not more than three advertisements in an international airport and not more than five advertisements in a railway station shall be for beverage alcohol products".

Besides exerting this control on media advertising, the LCBO has very strict groundrules about the content, physical location, and prominence of outdoors signs. This covers company promotion via company truck and other vehicles, novelties, premiums, giveaways, promotional literature, corporate public relations as related to educational or educational films and scholarships, the distribution of price lists, and notices of corporate appointments in publications.

One of the more intriguing changes in the directives showed a sexist connotation. In 1974, brand and product advertising techniques were prevented from unduly exploiting "the FEMALE face or figure of any person . . . as the central theme of the advertisement".

In the revised regulations of 1975, the female stipulation has been dropped **and** the clause changed to "the face and figure of any person . . . . . "

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

A Program for Coordinators of Drug and Health Education and Services—for persons who have completed Masters' degree in health science/education or its equivalent who demonstrate potential for leadership positions as coordinators of Drug and Health Education and Services in school districts of New York State—Begins Spring 1975. Information: Dept. of Health Science, SUNY College, Brockport, N.Y. 14420.

A Program for Elementary Health Education—for elementary health education teams (i.e. elementary classroom teacher and school nurse-teacher from school districts who demonstrate potential for leadership in health education—Begins Spring 1975. Information: Dr. William Zimmerli, Health Science Dept., SUNY College, Brockport, N.Y. 14420.

Annual Meeting of the American Psychiatric Association—May 5-9, Anaheim, Calif. Information: Dr. W. E. Barton, Medical Director, 1700 18th Street, N.W., Washington, D.C. 20009.

First International Conference on Substance Abuse in Industry—May 6-9, Detroit, Michigan. Information: Special Programs Department, Society of Manufacturing Engineers, 20501 Ford Road, Dearborn, Michigan 48128.

37th Annual Scientific Meeting, The Committee on Problems of Drug Dependence—May 19-21, Washington D.C. Information: Executive Secretary, Committee on Problems of Drug Dependence, NAS-NRC, 2101 Constitution Ave., N.W., Washington D.C. 20418.

Institute on Crime, Justice and Heroin—May 19-June 3, London, England. Information: Dr. A. S. Trebach, Centre for the Administration of Justice, The American University, Washington, D.C. 20016.

Southeastern Conference of Alcohol and Drug Programs—May 21-23, Biloxi, Miss. Information: Harold Armstrong, Division of Alcohol Abuse and Alcoholism, 125 Leila Court, Jackson, Mississippi 39216.

Medical Aspects of Alcoholism—In Search of Early Diagnosis and Treatment—May 27-28, Louisville, Ky. Information: Joe Trabue, Dept. HPER, University of Louisville, Louisville, Ky. 40208.

Physical Illness and Family Therapy—May 30-31, Toronto, Ont. Information: The Director, Division of Postgraduate Medical Education, University of Toronto, Toronto, Ont., M5S 1A8.

10th Annual Conference of the Association of Halfway House Alcoholism Programs of North America, Incorporated—June 8-11, Hot Springs, Arkansas. Information: Jack Shea, Conference Coordinator, Association Office, 786 E. Seventh St., St. Paul, Minnesota 55106.

New England School of Alcohol Studies—June 8-13, University of Vermont, Burlington, VT. Information: Jan S. Durand, Coordinator, P.O. Box 11009, Newington, CT 06111.

21st International Institute on the Prevention and Treatment of Alcoholism—June 9-15, Helsinki, Finland. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

American Medical Association Meeting—June 14-19, Atlantic City, N.J. Information: Dr. J. H. Sammons, Executive Vice-President, 535 N. Dearborn Street, Chicago, Illinois 60610.

Joint Meeting of the Canadian Medical Association and the Alberta Medical Association—June 22-27, Calgary, Alberta. Information: Ms. H. Otto, CMA, Box 8650, Ottawa, Ont. K1G 0G8.

Rutgers Summer School of Alcohol Studies—June 22-July 11, New Brunswick, N.J. Application deadline May 1. Information: Miss L. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

Summer Alcohol and Alcohol Education Institute—June 23-July 11, State University College at Brockport. Information: Dr. John S. Sinacore, Professor of Health Science, State University of New York, College at Brockport, N.Y. 14420.

First Annual Deep South School of Alcohol Studies—July 6-11, Shreveport, Louisiana. Information: Sam D. Thomas, Director, Deep South School of Alcohol Studies, Centenary College, P.O. Box 4188, Shreveport, Louisiana 71104.

Triennial Refresher Course for Alumni of Rutgers Summer School of Alcohol Studies—July 13-17, New Brunswick, N.J. Information: Miss L. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

Sixth International Congress of Pharmacology—July 20-25, Helsinki, Finland. Information: Secretariat, Sixth International Congress of Pharmacology, Siltavuorenpenger 10, SF-00170 Helsinki 17, Finland.

Seventh Annual Summer School on Alcohol and Other Drugs—August 4-15, Berkeley, Calif. Information: Herman J. Kregel, Director, Berkeley Center for Alcohol Studies, Pacific School of Religion, 1798 Scenic Ave., Berkeley, Calif. 94709.

Institute on Addiction Studies—August 17-22, McMaster University, Hamilton, Ont. Sponsored by Alcohol and Drug Concerns, Inc. Information: David Reeve, 15 Gervais Drive, Don Mills, Ont.

Fifth International Conference of the International Association for Accident and Traffic Medicine and the Third International Conference on Drug Abuse of the International Council on Alcohol and Addictions—Sept. 1-5, London, England. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1975 Annual Meeting of the Alcohol and Drug Problems Association of North America—Sept. 14-19, Palmer House, Chicago. Information: Alcohol and Drug Problems Association of North America, 1130 Seventeenth St., N.W., Washington, D.C. 20036.

Positions Available

BC — AN EXPERIMENT IN IDEALISM

By PETER THOMPSON

VANCOUVER—British Columbia, the wealthiest socialist enclave in North America, is in many ways the microcosm of the social idealism mooted elsewhere on the continent.

As a social experiment, some see it as the first real opportunity in North America, the first chance for progress in a jurisdiction than can afford it.

As an area in which to bring about change, the province has major advantages. It is young—Vancouver itself is less than a century old—and this may make British Columbians more socially malleable than people in older, more established areas of North America.

Its communities are generally heterogeneous rather than monolithic. And in spite of a rapid influx of immigrants from

Mr Barrett

Mr Stein

the rest of the continent, the population remains small.

For social experiment there are other advantages. In the second half of this century, BC fell behind other parts of North America in social programs. So little would be required to improve it.

Perhaps most important in the drug field—British Columbians seem to want change.

The province has the highest per capita rate of alcoholism in Canada and more than half of the country's heroin addicts. Crime has increased dramatically and is predicted to accelerate. Much of the crime is associated with drugs.

This then is the atmosphere surrounding the BC Alcohol and Drug Commission formed by the New Democratic Party government in June 1973, less than one year after it came to power after two decades of Social Credit rule.

The commission is headed by J. Peter Stein, a social worker; who reports to the Minister of Human Resources, Norman Levi, a social worker; who answers to Premier David Barrett . . . a social worker.

Since its formation, the commission has tried to pull together from existing agencies in the province an entirely new infrastructure for the treatment of chemical dependents.

It has rejected a "law-and-order" or compulsory treatment approach to hard drugs and has remained as invisible as possible to the majority of British Columbians.

Most of the commission's public statements, virtually all through Mr. Stein, have repeated that there is no panacea for drug abuse.

Most drug abusers do not want treatment, recovery rates for heroin dependents is less than 10%, and most treatment programs are a waste of money, Mr. Stein has said.

These views have earned the commission some enemies. Those who are concerned only with hard drug problems and want a hard-line approach are disappointed with it. So are those who would feel more secure in the presence of a government agency that advertised itself to the public.

Yet another group of critics is made up of those more familiar with the drug field. Many of these people fault the commission for the tenets on which it operates and for its internal administration.

A fundamental principle of the NDP government is that in matters of social needs, the local population is the savant.

Social problems such as drug dependency should be returned to the community where they originated, the government says.

The community knows best what its problems and priorities are, according to the NDP populist thinking.

Those that oppose this approach say it invests in the community, properties that are almost mystical. Though decentralization may be a good thing, these critics say, sanctifying the community to the point of dogma is wrong.

Two members of this group of critics are the former directors of the Alcoholism Foundation and the Narcotic Addiction Foundation, the two major private agencies among the 80 or so which were working in the field when the commission was formed.

"I think it's a beautiful philosophy," says Douglas Denholm, former NAF executive director, "but I doubt whether it will work.

"I don't want to sound negative. Given the philosophy of the present government, I think it simply must be tried. I don't think anything will be lost by trying it.

"In the long run I think you'll see developing over the province vastly different standards of care and treatment, and this won't simply apply to drug dependency.

"You'll find vastly different standards of care applied to the battered child, the deserted wife—all the different social problems—depending on the communities' views of their social priorities."

Edward "Ted" McRae, former AF executive director, says: "I can't really argue with the basic philosophy of the commission. I agree people at the grassroots should have some input into the planning process. I don't think they should control it 100%.

"I don't think they have the information, training or expertise which gives them the right to be the only decision makers."

The commission has taken over the responsibility for channeling government funds to various groups in the field. It is using its power over funds to try to bring some order into the chaotic treatment situation.

It has taken over the NAF and AF. It is establishing minimum standards for the people who will be providing care through a plan for staff evaluation. And it is encouraging a continuum of services by forcing local agencies to plan to integrate their services with other services in their areas.

In keeping with its philosophy of local responsibility for the administration of programs, the commission looked forward to the creation of "human resource boards" throughout the province. Championed by the Human Resources Minister, the boards would co-ordinate all social agency activities in their areas.

It was an attempt to regionalize social services by decentralizing decision-making from Victoria and co-ordinating services at the local level through one organization responsible to the community it served.

Human resource boards are slowly being established in the province. So slowly that in some areas the commission has had to go with whatever local administrative structure is available. In Vancouver, for example, administration of the NAF has been transferred from the commission to the Vancouver Resource Board.

It is the division between program and administrative responsibility and the manner in which the commission is co-ordinating its activities, that concern Mr. Denholm and Mr. McRae, both of whose contracts have been bought out by the commission on generous terms.

Both believe local administration will lead to differing standards of treatment which eventually will become unmangeable. And both say the commission is lacking in administrative support.

Mr. McRae says that of the seven commissioners appointed, only two have had extensive experience in the field: Peter Stein, a former member of the LeDain Commission who at one time worked in rehabilitation in Vancouver; and Ted Milligan, who was recruited from the Addiction Research Foundation of Ontario to the NAF by Mr. Denholm.

"The commission runs out of two offices, one in Vancouver and the other in Victoria. Milligan and Stein have never shared an office from day one. So there is always conflict, if you like, between Victoria and Vancouver," says Mr. McRae.

"Each has worked out of his own office (and they are) separated by 80 miles. The two senior men should rub shoulders daily for a considerable length of time so they can share each others thoughts and be able to build a coherent structure."

Mr. Denholm is more blunt. "It's absolutely absurd that the commission's head office should be in Victoria. The action," Mr. Denholm says, "is in Vancouver and that's where the commission should be."

"Another mistake," says Mr. McRae, "is to give each one of the appointed commissioners a management responsibility for part of the program. Here you have the board of directors judging themselves. You can't have it both ways."

Mr. Denholm agrees. He says the commissioners are "dabbling" in administration, "a field in which they have little to recommend them and which they bloody well wouldn't have to do if they had good administrative back-up.

"They have some very good people on their administrative staff but its been pulled together like topsy."

A better administrative structure, suggests Mr. McRae, would have been for the chairman to concern himself with external affairs, political and public relations, while another full-time employee of the commission took on the major responsibility for internal management.

So far, Mr. Stein has deliberately maintained a low profile for himself and the commission and in Mr. Denholm's opinion this is a mistake.

The commission's "major problem at the moment is its credibility," Mr. Denholm says. "It has not successfully projected its image, hopes, aspirations, objectives to the public.

"No program in this field has any hope of success unless the public understands it and largely agrees with it. I don't think the public yet understands what the commission is trying to do."

This is unfortunate, he says, because "it's doing some good things and some good things are coming".

Though it is true that Peter Stein and the commission prefer to work in relative anonymity, commissioners are accessible and not reluctant to discuss their activities.

Mr. Stein defends his small interest in traditional public relations as a matter of personal style. The importance of the commission's programs is best known by the people who use and supply drug services at the local level, he says.

"If they in the local community don't feel the impact, if they don't want to speak about what's happening, then we haven't reached people in the way in which I hoped we would," Mr. Stein says.

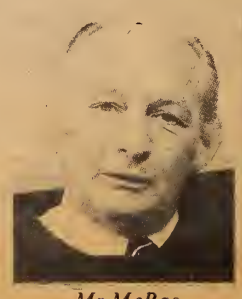
"You may think that's idealistic crap, but that's the way I feel about it," he says.

The criticism that the commissioners themselves shouldn't be involved in administration he takes more seriously. When the commission was set up two years ago, the commissioners didn't want to hire administrators immediately because the commission didn't know what kind of a job needed to be done in the drug field, nor what needed to be administered. So for the first few months, he says, the commissioners did the work themselves. An added advantage of this approach was that the commissioners "got their noses dirtied".

At the end of the commission's first year, says Stein, administrators were hired in the expectation that the commissioners would be able to withdraw from the day-to-day activities of the commission. That withdrawal has yet to occur, because he thinks the advantages of having the commissioners involved outweigh the dangers.

Stein has worked in other provinces where commissioners play a more traditional role "and they never know what the hell is going on. They come to meetings once a month, make some very important financial and policy decisions based on information that they've probably only glanced at which some staff person put together.

"We all know that that arrangement is very unsatisfactory. I also realise that this (the BC commission's) arrangement can be very unsatisfactory, not only to the staff but to the commissioners, because they have to be slightly schizophrenic in the sense in which Saul Alinsky spoke of integrated schizophrenics."



Mr McRae

Mr Denholm

The administrative structure of the commission will be looked into in the next few months, he says. Though there were few staff members the first year, they increased in the commission's second year of existence.

How individual commissioners interact with the development of various programs and other internal administrative questions "are put for grabs and open to re-examination," according to Mr. Stein.

He dismisses the criticism that he should be located in Vancouver, the heroin capital of Canada, rather than Victoria. Having a head office in Victoria is the administrative situation of every agency of the provincial government and as a result he spends two days of every week in Vancouver commuting from Victoria like many other senior government officials.

Critics who say the commission is mad to allow the community to have control over services funded by the commission are right, he says, but only because they don't know what the commission is doing.

If the critics knew what was going on, they might complain that the commission was being too authoritarian at the local level, he says.

The commission imposes standards of a system of care on communities wanting funding. In the case of treatment, the rehabilitative care system includes detox, out-patient counselling and residential treatment centres. And the commission will support a psycho-social model of detox centre and not a medical model.

If community agencies receive funding through the commission, they have to subject themselves to monitoring of their programs, auditing of all expenditures regardless of source of funds, and accreditation and training of their personnel, he says.

The commission uses its funding as a lever "unquestionably and without apology," Mr. Stein says. "The notion that the provincial government can delegate away its authority and responsibility for the development of basic health and welfare services is nonsense."

Despite Stein's own dislike of compulsory treatment the commission will re-examine the possibility of compulsory treatment when its voluntary treatment programs have been fully developed in about one year, he says.

THE BACK PAGE

Alcoholic mothers risk retardation of infants

By HARVEY McCONNELL

MILWAUKEE—Chronic alcoholic women who become pregnant run a definite risk that their offspring will be retarded.

But, investigators from Boston University, University of Washington, and University of California (San Diego) schools of medicine make it clear their data on the fetal alcohol syndrome covers only a small number.

Whether social drinking during pregnancy can affect the fetus adversely is still in doubt. All three teams plan to carry out future research in this field.

Their reports to the annual meeting of the National Council on Alcoholism here point out that not all chronic alcoholic women give birth to retarded infants and that women who are recovering alcoholics have delivered normal infants.

It is not known as yet whether damage to the fetus occurs early or late in the pregnancy.

The three teams have decided to meet on a regular basis in future to plot common guidlines, such as the type of interview schedule and the method of newborn examinations.

Drs. Henry Rosett and Eileen

The woman alcoholic—pg.7

Ouellette, of Boston University, found in a prospective study of 82 births that nine were to women who were chronic alcoholics. Only one of the nine infants is considered normal.

Drs. David Smith, K. L. Jones and J. W. Hanson, of University of Washington, have found that one-third of the infants born to chronic alcoholic women have the fetal alcohol syndrome and close to one half have varying degrees of mental deficiency.

The mental deficiencies have been studied by Dr. Ann Streissguth, of the department of psychiatry at the university, and show that those with the clear features of fetal alcohol syndrome are the most retarded.

Dr. Kenneth Jones of the University of California (San Diego) said a pattern of altered growth and morphogenesis has been described in 16 children born to women who were severe chronic alcoholics. Since these initial reports he and his colleagues have seen an additional 31 cases and numerous others have been called to their attention by investigators around the world.

Dr. Rosett, commenting on the reports, said until it is really known what the relationship is, if

See Babies—page 3

The Journal

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Athletes face doping controls

By DOROTHY TRAINOR

MONTREAL—The medical commission of the International Organizing Committee (IOC) for the Olympic Games has announced final ratification of extensive doping control measures for the Games to be held in Montreal in July, 1976.

The Commission, headed by Prince Alexandre de Merode of Belgium, told a press conference that the first four placers in each event, and other competitors selected at random, will be required to provide urine samples to be tested at a special Olympics laboratory in Montreal.

A major concern remains the anabolic steroids which are used mainly in sports where weight gives an advantage.

"Remarkable progress has been made in the past few years on steroid detection," Dr. Albert Dirix of Belgium, also a member of IOC, told the press conference. "Mainly we can detect them now using only a urine sample."

Olympic Village

Prince Alexandre de Merode agreed there should be no real cause for concern with respect to steroid detection, but admitted there are new kinds of steroids available for which tests have not yet been developed.

"We hope such tests will be produced by 1976 but medicine is always lagging behind laboratory science."

Anabolic steroids are known to add weight, but the suggestion that they build muscle is debatable, according to Col. Georges Letourneau (MD) of the Montreal committee's medical commission.

"Weightlifters, discus, shot, and hammer throwers particularly favour steroid use. But for steroids that can be pinpointed by existing tests, there will be no errors—you can be sure."

See Olympics—page 6

Cocaine claims the spotlight

OTTAWA—During 1974, cocaine was the "action" drug among the narcotics (not including cannabis).

While known heroin users in Canada only increased 13%, to slightly more than 10,000, the known cocaine users increased 173% to 774 individuals.

Like heroin, cocaine use is concentrated on the west coast and in Ontario: 41% of known cocaine users were in B.C.; 16% in nearby Alberta; and 28% in Ontario.

The comparable proportions for heroin are a little more skewed toward the west coast, with 63% of the known users in British Columbia; only 9% in Alberta; and 17% in Ontario.

There are 300 known opiate users, most of them in Ontario and B.C., in that order.

Interestingly enough, the main increase in narcotic users in Canada occurred outside of B.C.

In Alberta, known narcotic users amounted to more than 1,100 persons, an increase of more than 25%.

In Ontario, the increase was even greater: more than 35%, for a new total of 2,400.

In the Maritimes, the increases in known users were registered in the hundreds of percents, though numerically the total number is only 133 or about 1%.

Keeping up with inflation, the number of persons who became addicted to narcotic drugs (and known to federal authorities) as a result of medical treatment increased by 12%, to 168. The names of these persons are automatically removed from the federal list of known narcotic users after five years of having no reference to narcotic use.

Meanwhile, medical professions known to have become addicted to narcotics increased by almost 10%, to 125.

As with information on other known drug users, the information on known narcotic drug users was obtained by the federal bureau of dangerous drugs principally from police reports (about 64%). The rest of the information was obtained mostly from reports from drug treatment centres and from checking of pharmacy prescription records.

'A SPOT OF TEA, ANYONE?'

MILWAUKEE—Official functions in Australia now feature non-alcoholic beverages along with the spirits because a recovering alcoholic doctor had the panache to tackle the Governor about it.

Dr. John Moon, president of the Australian Foundation on Alcoholism and Drug Dependence, said the doctor, a friend of his in Canberra, was on the Governor's visiting list and always found at official receptions that all he could get was excellent Scotch.

"He had the confidence in his recovery to go up to the Governor and say 'look, it is time you laid on some fruit punch and some soft drinks. I am an alcoholic.' "

Dr. Moon, attending the annual forum of the National Council on Alcoholism here said the Governor was so impressed by this that he invited the doctor back to tea the next afternoon.

"After listening to his quiet story of recovery and rehabilitation back into society his final words were 'sir, I admire your courage.' " Non-alcoholic beverages soon made an appearance at functions.

In Quebec

Addiction services left in no-man's-land

By DOROTHY TRAINOR

MONTREAL —OPTAT, the Quebec foundation dedicated to prevention in the fields of alcoholism and drug addiction—the second largest such foundation in Canada—has been virtually phased out of existence.

Well, OPTAT still lives but is barely breathing. (OPTAT stands for Office for the Prevention of Alcoholism and Other Toxicomanias.)

OPTAT was established in 1968 by special legislation which is still on the books. Bill 292 gave OPTAT its mandate and appointed Dr. Andre Boudreau its director-general.

"Yes, OPTAT still exists," Dr. Boudreau remarks ruefully, "and I'm still its director-general. But I'm captain of a phantom ship—and with almost no sailors."

Addiction services in Quebec, whether that refers to alcoholism or drugs, are now in a kind of no-man's-land, at least for the time being.

Whether or not health planning with respect to addiction turn out to be a disaster or a blessing remains doubtful.

Almost all staff of the Ste-Foy facility of OPTAT (with respect to education, research and consultation) have been absorbed into Quebec's Department of Social

André Boudreau

Affairs in various capacities. But thus far, no special group exists within this Department to handle drug and alcoholism problems.

At the same time, the man whose work over a 20-year period spearheaded these areas and was instrumental in evolving OPTAT, Dr. Andre Boudreau, has been appointed a special councillor in the fields of alcoholism and drug addiction to Justice Minister Jerome Choquette. He also chairs the gov-

See OPTAT—page 4

Canadian commissions vital says retiring Alberta head

by WALTER NAGEL

EDMONTON—The need for citizen-directed addiction commissions becomes more crucial as Canada moves toward the 1980s, says the retiring head of such an agency in Alberta.

Richard M. Anthony, who became chairman of the Alberta Alcoholism and Drug Abuse Commission two years ago, leaves the province at the end of June, to join a law practice in Victoria, British Columbia.

He cites personal career ambitions, family considerations and accomplishment of goals with AADAC as among the "combination of many things" which prompted the move. No successor has yet been designated.

Although he is leaving the Alberta Commission chairmanship, Anthony considers the group's continued function essential, because of probable social behavior in this country during the next decade.

Beverage alcohol consumption has increased "remarkably" in recent years, and so have the associated problems. The trend is

See Commissions—page 2

...INSIDE

1974 STATISTICS

Drug offenders escaped jail terms

OTTAWA—Ninety percent of persons convicted of drug crimes under the Narcotic Control Act during 1974, including cannabis crimes, were spared the punishment of even a short jail term, according to statistics released by the federal bureau of dangerous drugs.

And 63% of the 30,485 persons convicted in Canada of drug crimes involving narcotics during 1974 were given only fines.

But only 18% of those found guilty were allowed to escape without being formally convicted and instead given only an absolute or condition discharge.

Since more than 90% of those found guilty were involved with only marijuana or hashish, that meant that the large majority of cannabis users caught and convicted were given criminal records.

(The distinction between the criminal record received when one is actually convicted and the criminal record of guilt accompanying a discharge is academic in many ways, Federal Solicitor-General Warren Allmand admitted in an interview with **The Journal**. But the federal government has legislation already prepared, for introduction in the Parliament this fall, that will make the distinction much clearer.

In fact, Mr. Allmand said something will be done to make sure persons given a discharge, either absolute or conditional, don't have to worry about the stigma of a record. criminal or otherwise.

For all narcotic drug convictions, there were increases in the numbers given punishments as harsh as six months in jail but decreases in the numbers given stiffer jail sentences.

The largest numerical increases were in the numbers given absolute discharges (up 96%, to 2,303 out of a total of 30,485 convictions) and conditional discharges (up 75%, to 3,248).

The absolute and conditional discharges are only a couple of years old as sentencing alternatives in drug crimes. They are comparable to a suspended sentence with probation in the case of a conditional discharge and a suspended sentence in the case of an absolute discharge.

The main difference is that technically at least, there isn't a conviction. And a pardon from the "criminal" record can be obtained much more quickly than if the person was actually convicted after being found guilty.

Sentences involving "fines only" rose 42% to 19,336, representing 63% of total convictions (the same proportion as 1973).

By BRYNE CARRUTHERS

Some 2,535 individuals were given suspended sentences or probation, an increase of 16% compared to 1973.

For cannabis possession crimes alone, 69% of those found guilty were given a fine only as punishment; 7.7% were given probation or a suspended sentence; 20% were given an absolute or conditional discharge (compared to 17% in 1973); and 3.7% were given jail sentences from less than 1 month to between 2 and 3 years.

For trafficking in cannabis, the courts were a little tougher, giving out jail sentences from 1 month to 2 years for 60% of those found guilty. One individual received a 7-to-8-year jail sentence.

Persons found guilty of possession of cannabis for the purposes of trafficking were given jail sentences most of the time: up to three years in jail for 67% of the cases, with two individuals getting 5 to 6 years.

For importing of cannabis, 23 were given the 7-year minimum jail sentence and one case involved an 8-to-10-year jail term.

For cultivating cannabis, the stiffest jail sentence was 2 to 3 years in three cases. But 56% were spared jail sentences, and most of these given fines only.

Some 53% of those found guilty of possessing heroin during 1974 were given non-jail sentences. In fact, six were given conditional discharges. The largest single group among those given jail sentences was in the one month or less category. The stiffest sentences for simple possession were 3 to 4 years in jail.

Heroin traffickers, by contrast, were most likely to be sentenced to 1 to 6 years in jail.

On one extreme, one heroin trafficker was given only a fine. Another was given 8 to 10 years in prison; another 20 years or more; and three were given life imprisonment.

Most persons convicted of possessing narcotic drugs other than cannabis or heroin were given only fines.

Hallucinogenic drugs popular

OTTAWA—The federal government has files on some 17,083 known users of hallucinogenic drugs such as LSD.

The names of some 3,630 individuals, most of them males, were added during 1974.

During 1974, another 146 individuals already with files in the federal bureau of dangerous drugs and identified as hallucinogenic drug users were arrested on drug charges in Canada.

Of the more than 3,600 new names added during 1974, 3,183 were males.

The majority were under 24 years of age, with 451 individuals under 18-years-old. The latter group included two 14-year-old boys, 44 15-year olds, mostly boys, and 116 16-year-olds.

LSD users continue to top the list of newcomers, with more than 2,300 LSD users given their own file during 1974, up 50% from 1973.

MDA, which seems to have become less popular, was involved in about 1,000 of the new files opened for hallucinogenic drug use.

Cannabis tops poll

OTTAWA—Despite the supposed emphasis on catching users of "harder" drugs rather than cannabis users, the number of cannabis convictions in Canada during 1974 increased by 46% compared to 1973, according to the latest statistics from the federal bureau of dangerous drugs.

Cannabis convictions, out of all narcotic drug convictions, rose from 93% of 21,469 convictions in 1973 to 95% of the much more numerous 30,485 narcotic drug convictions during 1974.

And despite the supposed emphasis on trying to catch more traffickers and importers instead of just drug users in Canada, the number of convictions during 1974 for simple possession of cannabis rose 46%, to 93.6% of all cannabis convictions.

In 1973, simple possession cannabis convictions made up 93% of total cannabis convictions—meaning that at best there has been absolutely no change for the better since 1973.

Meanwhile, heroin convictions were down 38%, to 798 in 1974.

Morphine convictions under the Narcotic Control Act were up 80% to 27.

And convictions involving phencyclidine, a psychedelic used as a tranquilizer in wild animals, were up a dramatic 1,237%, to 254.

Cocaine, a new drug on the Canadian drug scene of late, was involved in 237 convictions in 1974, up 9% from 1973.

Overall, possession convictions under the Narcotic Control Act were up 44% compared to 1973 and represented 92% of all convictions.

Trafficking convictions rose 15%, representing 2.3% of all convictions.

File lists "known cannabis users"

OTTAWA—Some 36,494, mostly young, mostly male, Canadians have their names in a special file at the federal bureau of dangerous drugs in Ottawa.

The file is called "Known cannabis users in Canada" and contains 104,862 names accumulated since early in the 1960s—at least, as of Dec. 31, 1974. The number has probably jumped another 20,000 since then.

More than 32,000 of the new files are for males.

Eighty-two percent of the new files involves persons under 24 years of age.

The files will remain at the health department until the individual gets a federal pardon (and even then files are often kept open when pardon notices are not received by the dangerous drugs bureau) or if and when the government decides to destroy the files.

Included are eight 12-year-olds, six of them boys; 19 13-year-olds, 12 of them boys; 101 14-year-olds; 484 15-year-olds; and 1,444 16-year-olds.

There are also four new files for persons 70 or older.

The filing clerks at the federal bureau of dangerous drugs, all of whom have security clearance, were busy during 1974. They had to open more than 50 percent more files in 1974 than in 1973, three times the number opened in 1970-72.

They also had to pull the files of 3,741 males and 164 females already on the list, when these individuals with previous cannabis records were caught again in 1974.

The records also indicate that seven individuals arrested during 1974 were in possession of what the police regarded as an offensive weapon.

Meanwhile, persons already with their names in the "known cannabis user" or known hallucinogenic drug user" files graduated to the heroin-user and other narcotic drug-user files in 1974.

One hundred and fifty-four former cannabis or hallucinogen users were found using heroin; 100 using heroin and methadone; 104 using cocaine; and 49 using PCP, or phencyclidine.

Most cannabis users were caught during December, for some unexplained reason, according to federal records.

"Commissions crucial" – AADC chairman steps down

(Continued from page 1)

likely to accelerate as more kinds of liquor sales outlets become authorized, and as people earn more disposable income.

"The hard drug problem will not be anywhere near the problem with alcohol," he predicts, unless there is a radical—and unforeseen—loosening of current drug control laws.

Chemical abuse and narcotics addictions have a severe individual effect, but the social impact of the problem, even when criminality is involved, has been somewhat less than once was feared.

Anthony is saddened by the recent dissolution of a similar addiction commission in Quebec, and he scoffs at the notion that "a civil servant behind a desk somewhere" can substitute for the semi-independent direction of an appointed citizen chairman.

Anthony insists that an in-government operation is inferior to the Commission system utilized in Alberta, where he is broadly accountable to a cabinet minister, but politicians do not directly influence the detailed allocation of funds. He considers AADAC's role, and his own as chairman, as that of a special advocate to Government, rather than an integrated part of it.

"We're like the proverbial crystal of sand inside the oyster shell. They either have to pearl-ize us or get rid of us," he explains.

Anthony seems to have made the system work fairly well, during the past two years steering such a fine idealogical one that some members of the governing conservative party were in public disagreement over agency operations.

Richard Anthony

As AADAC's first full-time chairman and executive director, Anthony has watched the Commission's annual budget more than triple.

In the current year, the Alberta Alcoholism and Drug Abuse Commission will spend $5.6 million, about $4 million of that for educational and treatment services directly under AADAC auspices, and about $1.2 million for work among the substantial native populations within the province. Anthony likes to point out that only about 10% of budget funds go toward administration.

He has made it an objective to retain skilled staff in front line positions serving clients, rather than having to go into management within the Commission in order to improve personal earnings.

Alcoholism counsellors, for example, now can attain a top salary in the $16,000 to $17,000 range (with a further raise in the offing this summer) which overlaps the AADAC management-administrative route, where pay scales begin at approximately $14,000.

The Commission chairman's position, which he is vacating, pays $32,000 to $40,000 annually, about the salary level of a Government deputy minister in Alberta. That sum is certainly adequate to attract suitable administrative talent for the job. Anthony suggests.

Money, however, is only one aspect of the chairmanship. He considers personal commitment to be at least as important, because of the probability that AADAC will be involved in controversy if it carries out its work properly.

"Anything worth doing involves a realignment of thought. and so you sometimes end up at the focal point of a crisis."

The only way to escape such a process, as he views it, is "to cease to be innovative—you cease to perform the function indicated by the job."

Anthony intends to specialize in litigation, and in "public law" where the rights of individual citizens are affected by government boards, agencies and tribunals.

He says the Alberta Alcoholism and Drug Abuse Commission has developed a solid basis of services, administration, staff and the potential for flexibility and expansion in dealing with a "very difficult" area of social behavior.

"It has been overlooked so long—it's going to take a lot of thought by government, and by the community."

Healers handle alcoholics

MILWAUKEE—A majority of alcoholics in much of Latin America are being treated successfully by healers because most people only seek medical aid in dire circumstances.

Dr. Juan Carlos Negrete said that one town in northern Peru is noted for having treatment entirely in the hands of a group of healers. Local industry refers workers to them and doctors who live there are happy because they know the healers are best at handling alcoholics.

Dr. Negrete said that in his position as mental health consultant to the Pan American Health Organization, stationed in southern Brazil, he has seen the centers with healers in attendance flourishing. Only a patient taken by the police or whose behavior is extreme enters the health service for treatment.

"NON-MEDICAL" LABEL A DETOX FALSEHOOD

MILWAUKEE—The Canadian and American public are being sold a false bill of goods with detoxification centres that are labelled non-medical.

Instead, they should rightfully be called sub-acute centres, argues Dr. Donald Pittman, director of the department of sociology at Washington University, St. Louis, and a pioneer in setting up North America's first detoxification center.

"The term non-medical detoxification centre is a contradiction in and of itself. To detoxify a person means to return him to a state of being alcohol free, and this is best done in a medical context.

"When you talk to people who run such centres they will always say 'we have medical backup.' Well, if they have medical backup and are providing routine medical examination, it is not non-medical, it is sub-acute."

Dr. Pittman, who was attending the annual forum of the National Council on Alcoholism here, added: "I think this is selling a false bill of goods to the public because it is basically done on economic grounds: that it is cheaper to run a non-medical detoxification centre.

"That is another contradiction in itself. If you want to try and sell cheap medical care you are still defeating the whole purpose that alcoholism is an illness that is deserving of adequate care.

"To say to the public 'we are doing this brilliant job with non-medical personnel,' when they have got medical people all over the place as backup, is just a fraudulent practice. Let us not quibble semantics: it could easily be called sub-acute."

Valium complicates methadone treatment

MONTREAL—For serious reasons, Canada's most widely prescribed tranquilizer, diazepam (Valium), is now virtually prohibited to methadone patients at the Royal Victoria Hospital's methadone clinic, Montreal.

The clinic's acting director, Dr. John R. Unwin, recently stated: "I am enforcing a near veto on the prescription of Valium in our methadone clinic. Only in exceptional circumstances will I prescribe it.

"We have told these patients they are just not going to get it and we don't want to find traces in their urine. If they need help with respect to sleep or nervousness, we prescribe other substances."

Dr. Unwin, an associate professor at McGill University and a senior psychiatrist at the Royal Victoria Hospital, is known as an authority on drug abuse. His clinical judgement with respect to these addicts' over-use of diazepam is based upon his own experience with methadone patients, upon observations with respect to young non-addicts, and upon a recent interview with Dr. Marie Nyswander.

(Dr. Nyswander, with Dr. Vincent Dole, evolved the Nyswander-Dole technique of methadone treatment for heroin addiction.)

Addressing a McGill University audience at the Allan Memorial Institute, Dr. Unwin said Dr. Nyswander advised him that they have found in their New York clinic that the toxic effects of the chronic abuse of diazepam seem worse than the effects of heroin or morphine—more like the effects of alcoholism.

"She is finding an enormous problem of control where methadone patients ingest diazepam indiscriminately over a prolonged period of time. Now she will prescribe diazepam only in special cases and for not more than one month. In any event, she says that in their clinic she does not give more than four to five tranquilizers at a time and then with great caution."

Apparently, the Nyswander findings (reported in an interview published in Vogue Magazine, January, 1975) are that in these patients a tolerance can be built up from continued abuse, and withdrawal effects can be particularly difficult.

Continued use can reverse pharmacological effects so that diazepam does not do what it is supposed to do. Serious depression may follow.

"Dr. Nyswander stated one of her great difficulties is the extraordinary amount of Valium being prescribed and available to methadone patients," Dr. Unwin continued.

"No wonder! In 1972 in the United States, $326 million dollars was spent on minor tranquilizers. Of this, $188 million was spent on Valium."

AFTERMATH

PARIS—Alcoholism kills almost 22,000 people a year in France, the country that has the highest rate of alcohol consumption and more cases of liver cirrhosis than any other in the world.

Official statistics, released by a government group studying alcoholism showed that alcohol kills 21,955 people a year.

Each year, the average Frenchman drinks 31 gallons of wine, according to the statistics.

Moderate drinkers outlast teetotallers

Long life for tipplers

By MARY HAGER

BERKELEY, Ca.—The moderate drinker appears headed for a longer life than either his heavy drinking or his teetotaling counterparts.

But just why is anybody's guess.

Robin Room, a member of the Social Research Group at the University of California's School of Public Health here, made the discovery with graduate student Nancy Day.

It was, he said, "a curiously persistent finding," one which—up to this time, at least—defies rational explanation.

"Nothing that seems to make sense explains it," he observed.

The finding emerged from an analysis of data gathered on 6,159 individuals in four past studies done by the group.

The results showed substantial increases in early death among frequent heavy drinkers and those judged to have a high number of "current" problems—such things as losing a job, troubles with wife, family, neighbors, police—from their drinking, a combined group which, he said, comprises 2-3% of the adult population.

But "for unexplained reasons, abstainers also seem to have a higher early mortality than moderate drinkers," he continued.

Results showed that the lowest mortality is for an intermediate frequency of drinking, that under age 60 the highest death rates are for those with the highest frequency of drinking and that above age 60, the highest death rates are for abstainers, he said.

Another "curious" finding is that occasional fairly heavy drinking "is less crucial to mortality" than regular patterns of fairly heavy drinking and that behaviors often taken as symptomatic of alcoholism—i.e. a drink first thing in the morning, sneaking drinks—are less important than the amount of drinking on an overall measure of drinking problems," he said.

Room reported that they had attempted to explain the paradoxical finding by controlling such factors as age, health, social status, frequency of feeling tense and smoking, but that, when these factors were controlled, the prediction of mortality by drinking patterns and problems measures actually improved.

"Thus," he suggested, "it seems that, rather than being confounded with the other mortality factors tested, the relationship of the amount of drinking to mortality is to a small extent masked by other factors."

He acknowledged there is "no question but that abstainers and drinkers differ in a lot of ways"

Robin Room

but the problem is the one which would explain the difference in mortality rates.

The fact that the occasional drinker outlived the abstainer was such a surprise, he added, that much of the data was re-examined. Nevertheless, the finding held, he said.

Also, it didn't seem to matter what the beverage was, for findings were the same for beer, wine and hard liquor.

He reported that among those under 50, increased mortality appears to be found among those who drink five or more drinks, four or more times a week, while among males in their 50s, the same amount of drinking shows some elevation in mortality rates when done one to three times a week.

The analyses showed no real "cut off" point as to what was a desireable amount to drink, he continued.

But, "our data on general mortality suggest that for amount of drinking, apparently unlike amount of smoking, there may be some kind of threshhold below which general mortality is little affected," he noted.

He continued: "In the absence of further evidence, in fact, we might well reinstate 'Antsie's limit' as a sensible suggestion on how to drink without a substantially increased risk of early death."

"Anstie's limit", he recalled, first proposed in 1864 and accepted as "safe" through the 19th century, was the "equivalent of one and one half ounces of absolute alcohol per day, or about three ounces of whiskey, half a bottle of claret or rhine wine, four glasses of beer; being understood that this is to be taken only at lunch and dinner and that the whiskey is to be well diluted."

The findings were included in a federally funded report on alcohol and health that was submitted to Congress.

Babies at risk

(continued from page 1)

any, between moderate drinking and the syndrome, a lot of retarded babies will be born. Many will be to women who will have one drink several times a week.

He would not say categorically that women should not drink during pregnancy. "I would hate to make all of them feel guilty about being responsible for their offspring's retardation without sufficient evidence.

"On the other hand, if my wife were pregnant I would tell her not to drink."

Dr. Jones said he agreed completely "but I think that the other end of the scale is the one that we don't have any question about whatsoever."

Senate completes cannabis hearings

OTTAWA—With luck, the federal government's new cannabis legislation should have cleared the Senate and be transferred to the House of Commons for consideration just in time for the summer parliamentary recess.

That will mean introduction in the Commons this fall, in competition with a horde of Bills either planned for the fall (including some important changes to the Criminal Records Act and the National Parole Act) or already before the Legislature but rapidly running out of time.

The Senate Committee on Legal and Constitutional Affairs, in the fine tradition of the Senate, undertook a thorough if underpublicized study of the marijuana scene. It considered the legal and social pitfalls of the government's specific cannabis bill and completed its public hearings late in April on a legal note.

The witnesses on the last day were officials of the federal justice department, who seemed intent on defending the status quo. They concluded that the criminal law and criminal sanctions should only be applied with restraint and should not be applied if cannabis is harmful only to the users.

At press time, the Senate committee had started in-camera meetings to consider all the evidence present during the hearings and to determine what, if any, amendments would be proposed.

The Committee's report was scheduled to be presented to the Senate late in May or early in June, depending on the length of time the Committee needs to sort out the conflicting scientific, social and legal evidence and advice on the impact of cannabis and of the proposed legislation.

One point emerged distinctly during the last days of the hearing: the government is not really proposing to "decriminalize" cannabis, as some have suggested, even if first offence possession convictions would normally only be punishable by a fine (jail only if the individual refused to pay the fine).

Cannabis crimes will remain "crimes" under the criminal code; persons arrested and charged with cannabis crimes will obtain a criminal record, in the form of fingerprints and a photograph, with the police. If the person is convicted, even if the only punishment is a fine, there will continue to be a further criminal record of conviction that can only be eliminated by obtaining a federal pardon.

And the government retains the right to reverse the pardon at some later date.

Police view:

Jail for second offenders

OTTAWA—The Canadian Association of Police Chiefs wants a minimum penalty, preferably some type of incarceration, for all cannabis crimes other than a first offence of simple possession. This would rid society of "the rotten apple in the barrel". Victoria Police Chief J. F. Gregory told the Senate Committee studying proposed changes to federal cannabis legislation.

Claiming there is a loss of an effective deterrence without such minimum penalties, Chief Gregory went on to explain that "the reasoning behind the second offence penalties seems rather apparent to me, a simple man:

"He did not learn the first time; therefore you hit him harder the second time."

The first time an individual is caught in possession of cannabis, "by all means, help the individual as much as possible", perhaps by puting the person into "an educational arena" where he "can be taught that future involvement in drugs will lead . . . to the inevitable end of destruction, self-destruction."

But if the individual commits a second offence, "it is obvious he did not benefit from the first experience so then you incarcerate him.

"You take him out of the society he is infecting and apply your social sciences to get to the root of the problem," Chief Gregory said, adding "we want to nip this as quickly and as decisively as we possibly can."

Later, he suggested that without such measures now, the drug problem might become so serious in Canada that much more drastic measures might have to be employed.

Chief Gregory likened the cannabis user caught a second time to "the rotten apple in the barrel" that society must remove to prevent total spoilage.

"There is something peculiar about the drug marijuana which makes people who take it become evangelists.

"They want to get a crowd around them and turn them on.

"Whether the marijuana user gets his kick out of this or what we do not know, but it is a known fact that he goes out and actively recruits other users," Chief Gregory asserted, explaining that he was talking about the crime of simple possession of cannabis.

OPTAT c'est fini

(continued from page 1)

ernmental committee on drug and alcohol advertising.

Unquestionably Dr. Boudreau still wields considerable influence and he assured **The Journal** that influence will be used to maintain and foster the good inter-provincial and international relations that have been built up in these specialized fields.

Nonetheless, educational, research and consultation services now exist in a kind of vacuum.

The changeover with respect to OPTAT relates to Quebec's now famous Bill 65. Through this bill, Claude Castonguay (then Minister of Social Affairs) envisaged a master plan for health care services. For this, he has been praised on many fronts as a visionary—damned on others.

The key element in the Castonguay plan was, and remains today, local community services centres, but these are only very slowly spreading throughout Quebec. The plan calls for individuals and families making initial contact at these centres for medical or social services. Problems presented might be medical or social with respect to birth control; adoption, alcoholism, delinquency.

Staffed by the spectrum of medical and social service professionals, these care and referral centres are to act as satellites for Quebec hospitals with their specialized facilities.

Quebec health planning under this master scheme is complicated and administered at various levels. At the top of the ladder is Social Affairs minister Claude Forget. A special council on health services makes recommendations to the minister. The idea behind the master plan is to give basic, continuous health and welfare services to the people of Quebec in a universally accessible way.

Now OPTAT's services have fallen into the same bag—the community services centres for front-line action. Certainly, from the government's view, alcoholism and drug abuse and addiction problems are part and parcel of community health and welfare services.

The Castonguay planning simply left no room for any separate administration in these fields.

Interviewed by **The Journal**, Dr. Boudreau said, "On a short-term basis, the planning is a disaster in our field. Maybe 'disaster' is too strong a word, but it is now impossible for alcoholics and addicts to go to community centres and ask staff to take responsibility. Now it is difficult to refer and hospitalize the alcoholic or addict."

"However," he added, "on a long-term basis, it may all work out. Possibly in five to six years, they will have to go back to a foundation such as OPTAT or the Addiction Research Foundation of Ontario."

Dr. Boudreau remains an optimist. Although OPTAT's one million dollar budget has been wiped out, Dr. Boudreau assures that two planned projects will take place. One is the congress of the Canadian Federation on Alcoholism and Drug Dependencies to be held in Quebec City Sept. 14 - 18.

The same is true this year with respect to the annual summer community education course in the treatment of alcoholism and drug addiction at the University of Sherbrooke.

OPTAT's role in community education has been taken over by the Department of Education, where the government feels it belongs. The OPTAT staff who had specialized in education areas are now dispersed within the Department of Social Affairs.

Effectiveness of propanolol challenged

By MILAN KORCOK

ANAHEIM, Ca.—The use of propranolol in treating opiate dependence remains a contentious issue.

But new research work, reported by a team from New York Medical College, seriously challenges claims that this beta blocking agent is effective in meeting any of the major needs of the heroin addict.

Speaking to the annual meeting of the American Psychiatric Association, Dr. Richard B. Resnick, noted that according to the findings of his group, propranolol neither prevented the euphoric action of heroin among addicts, nor controlled their craving for the drug.

Reporting on a series of three controlled studies among hospitalized volunteer subjects at the Division of Drug Abuse Research and Treatment of the Department of Psychiatry, Dr. Resnick said that even if subsequent research did turn up more positive uses for propranolol in controlling addictive behavior, its widespread use should be discouraged because of potential medical risks.

(Several volunteers had to be eliminated from the New York studies because of medical considerations due to abnormal cardiograms or histories of certain conditions such as bronchial asthma.)

The experiment, done on healthy male volunteers who had been heroin addicts for four to eight years, was conducted on a research ward with all subjects remaining in hospital throughout the experimental period. Propranolol tablets, 10 mg to 40 mg or matching inert placebo tablets were taken by mouth.

In assessing the effects of propranolol on opiate abstinence, four subjects were given dihydromorphone intramuscularly every six hours.

During the experimental period each subject was abruptly withdrawn from opiates on two occasions by having blind saline substitutions. Propranolol or placebo was given four times a day, for three days preceeding and on the day of opiate withdrawal.

Results showed no difference in the time of onset of withdrawal whether the subjects were receiving propranolol or placebo.

In assessing the effects of propranolol on the acute response to heroin given to detoxified individuals, 11 subjects—drug-free for five to seven days—were given acute intravenous challenges of heroin while receiving various dosages of propranolol or placebo.

Using various means to judge the addicts responses to heroin injection (pupillary diameter, heroin effect questionnaire, estimate of opiate quality, assessment of the high) the researchers found no consistent effect of propranolol. The mean values of each of the measurements remained almost the same, whether heroin was administered following placebo or propranolol.

"The results of these two first experiments indicate that propranolol exerts no antagonism to the effects of opiates," asserts Dr. Resnick.

But there remained the possibility that discrepancy between these and earlier clinical observations, particularly by Dr. H. J. Gross who did report positive effects of propranolol, might have been attributable to different patterns of heroin use.

Dr. Gross reported that propranolol did not effect the subjects' immediate response to heroin, but rather it shortened the duration of action of successive heroin injections.

"In order to rule out the possibility that propranolol may interact differently with chronically-administered heroin than it does with acute injections, we decided to replicate the field conditions as closely as possible," said Dr. Resnick.

To do this three subjects were maintained on 80 mg to 100 mg a day heroin doses for approximately four weeks, and one subject was allowed to intravenously self administer 96 mg of heroin per day for 24 days on demand.

During this period, 40 mg to 160 mg per day of propranolol was alternated with placebo every two to four days.

In no cases were there any signs of withdrawal, and whether the subjects received propranolol or placebo, their perceptions of the heroin "high" showed no significant differences.

"Although we found no evidence that propranolol relived the abstinence syndrome," says Dr. Resnick, he admits that the dosage used in that phase of the study was relatively low and "there remains a question of any potential benefit from higher doses."

"In addition, our study does not demonstrate any evidence of propranolol's ability to block heroin-induced euphoria."

Illicit use of methadone 'phenomenal' among addicts

ANAHEIM, Ca.—In the overall context of multi-drug use, the consumption of illicit methadone appears to be rising "phenomenally" among New York's addict population.

John Langrod, of the Drug Abuse Service at Bronx Psychiatric Center, told a panel of the American Psychiatric Association that 89% of the sampled group of 64 applicants to the Bronx program admitted to illegal use—that is use out of the prescribed program context.

The sampling was done in early 1975.

This evidence of increase was further supported by urine analyses on other applicants done prior to the sampling period. These analyses showed 84% using methadone illegally.

"It is not surprising that, according to the New York City Medical Examiner's Office, deaths related to methadone are increasing," said Langrod.

Within the context of multiple drug use, Langrod reports that 69% of the respondents in the sample also admitted using some other drug in addition to mathadone. Of these, 52% used cocaine, but there were only 6% problem drinkers.

The most dramatic case of poly-drug abuse in the group of applicants was a 30-year-old male with a reported $300-a-day heroin habit who answered "yes" to every other drug option thrown at him.

He stressed the easy availability of methadone and his preference for this drug over the "5%" heroin now available on the street.

The majority of those questioned report having started their methadone use in the years 1970 to '72.

In respect to the genesis of this methadone use, 71% of respondents who used street methadone began that use on the streets, and 51% of these subsequently entered a program.

Contrary to the conjecture that most methadone use is triggered by availability of that drug in a program, only 28% claim to have taken their first dose of methadone in a program.

Of those addicted to methadone at the time of the interview 53% said they used it every day.

Responses related to the addicts' means of obtaining methadone show some stark differences from the behavior of heroin users. The means of aquisition appear to be much more casual, informal, less urgent.

Only three people complained that their methadone was of poor quality, one of these saying that if it is cut too much he would get his money back and may "beat up" the one who sold it to him. This is a far cry from the heroin trade, were beating up a pusher is not customary.

The usual form in which methadone is delivered on the street is 25% in the form of diskets, 39% liquid, and 36% both diskets and liquid.

The majority of individuals questioned also declared that the methadone they usually received was of good quality.

In defining preferences, 60% of the addict-respondents preferred methadone for a broad range of reasons—its effects last longer, street heroin is "garbage", methadone's quality could be more easily trusted.

Strangely, only a minimal number said they preferred methadone use because of its price. Though most methadone addicts paid less than $10 for a street dose, which lasts three times as long as heroin, price seemed an inconsequential factor.

Understanding drug parlance can save life

DENVER—Slang words may be appropriate in the streets but in a hospital emergency room, they could mean the difference between life and death.

So, if a patient's friend said he took too many "horse hearts" too much "Miss Emma", or too much "gold dust", hospital personnel had better be able to translate quickly, says the director of the Rocky Mountain Poison Centre.

"This is a big problem, especially with abusive drugs", Dr. Barry Rumack told The Journal in an interview at the center in Denver General Hospital.

"There are multiple slang names for these drugs, all over the country, and they keep changing."

Dr. Rumack's answer to the problem is "Poisondex".

Poisondex is a system developed here and with an astonishing "memory" for names, whether the street or classroom versions.

The system is used in about 125 poison control centres so far, is kept up to date by personnel at free clinics over a wide geographic area, and once asked, will flash onto a small television screen all the information available on any of about 100,000 drug poinsonous substances.

"There's no cross-referencing with our system" Dr. Rumack said, because of the need for haste". So any time you look any drug slang term up, you get all the information about the treatment of that drug displayed on the screen."

For example, the worker looking up "horse hearts" will find what he needs on benzedrine poisoning; "Miss Emma" will elicit the details on morphine; and "gold dust", cocaine.

In addition, the printed material which flashes on the screen will give the pharmacologic properties of the drug in question, the clinical effects, and the range of its toxicity.

"On abusive drugs, we also indicate sometimes that, say, a certain drug is known as such-and-such in Colorado, whereas it may be known as something else in New York.

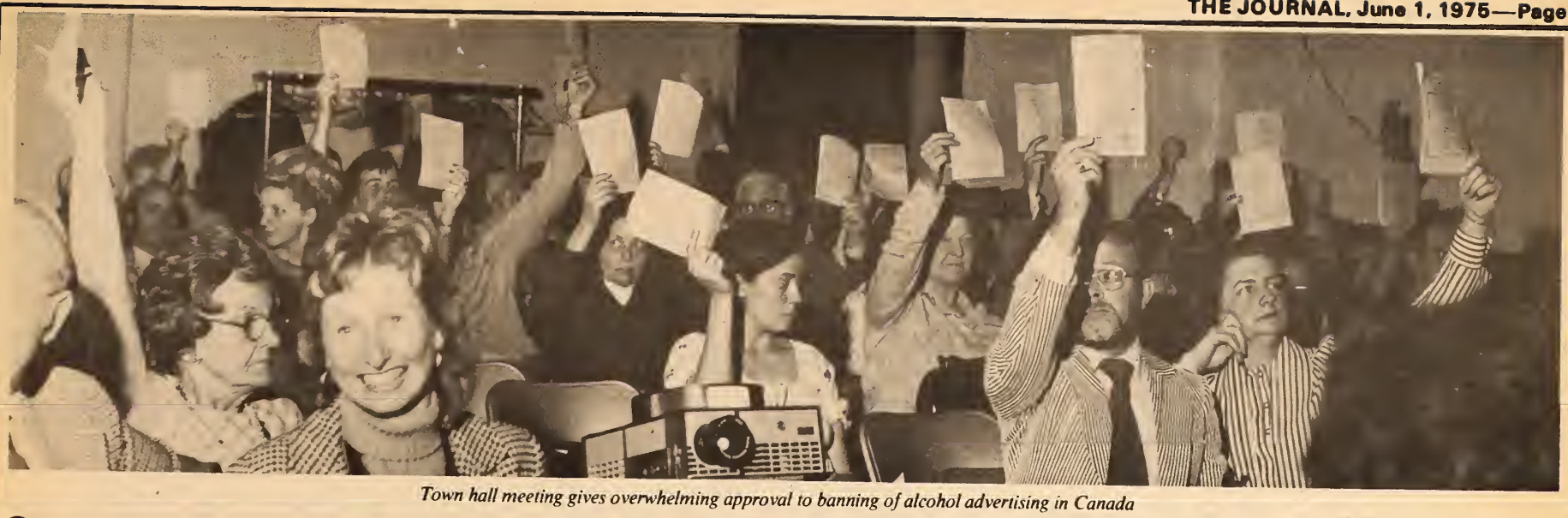
"When we started out we had a search on the streets of Denver for nicknames, and that's where we got our first listing. Now that we've got people helping us keep the nicknames up to date, from all over the country, the list has considerably expanded.

"What we do is send copies of our present list out to these people, at the free clinics, and say 'Hey, go through this list, and write on it, making any additions or corrections'."

The Poisondex system, for which he serves as editor, is available through Micrometics, Inc. in Denver. Dr. Rumack said the computerized system was developed for poison control because it's quicker, and because with a file card system, "you misfile one of those 10,000 file cards, and you may never find it again".

The Rocky Mountain Poison Center, which covers several Western states, had more than 18,000 calls in 1974, he said. About 30% of them were related to drug ingestion. The toll-free number is 800-332-3073.

Barry Rumack



Town hall meeting gives overwhelming approval to banning of alcohol advertising in Canada

Sex in ice cubes part of subliminal seduction

By BETTY LOU LEE

STRATFORD, Ont.—A town hall meeting here gave overwhelming approval to banning alcohol advertising in Canada, and then everyone went home to look for sex and skulls in the ice cubes of booze ads.

The meeting was, in fact, a formal debate on the resolution that alcohol advertising should be banned. And the hit of the evening was Wilson Bryan Key, PhD, author of Subliminal Seduction. That's the book that says everyone is being victimized, manipulated and sexually assaulted by subliminal messages aimed at them in print ads and TV commercials.

Dr. Key, of course, took the affirmative, and did it with a series of color slides of alcohol, cosmetic and tobacco ads in which he traced a plethora of genitalia, death symbols, suggestions of oral sex and arousals of an unconscious castration complex.

When Ralph Davis, chairman of the Association of Canadian Advertisers, followed in an angry rebuttal, he led off by saying, "I bet you thought you were coming to a debate, not a blue movie."

Dr. Key is a former Californian who has been in Canada six years and is on the faculty of the journalism school at the University of Western Ontario, London.

Hugh Edighoffer

Ralph Davis

The audience of about 150—all ages, but predominantly over 35—seemed to have some trouble accepting some of the images Dr. Key was finding in the ads. But one particularly brought instant murmurs. A cigarette ad showed two hockey players mixing it up, a discarded glove beside them.

The brand name on the glove seemed to be just indistinguishable lines. But magnified, those lines spelled out CANCER.

Why would a cigarette company want to draw attention to the link between smoking and cancer? And why would liquor manufacturers have skulls hidden among the ice cubes in their drinks?

It is Dr. Key's theory that it's an appeal to the young who are at an adventurous age and respond to a "live dangerously" approach. There were also possibilities of Freudian death wishes and the whole thing "has bizarre implications if self-destruction is the reason we smoke."

Some ads could even combine the sexual approach and the death wish: one cigarette ad had hidden snakes, which are both death and phallic symbols.

Dr. Key maintained these techniques have been used by the advertising industry for 25 years, and although a survey of 200 businessmen showed most of them thought subliminal advertising was illegal, he could find no such legislation in North America. A flurry of bills had been introduced in various legislative bodies after initial publicity about subliminal messages, but he could find none enacted.

He said despite serious allegations he made in his book, published 18 months ago, "there has been not one whisper of a libel action" although he had been subjected to "intense harassment".

Mr. Davis, who followed him, branded the whole concept as the Big Lie Theory. "You repeat it often and loud enough and somebody will begin to believe it."

As director of advertising for Kellogg Salada Canada Ltd., and a 20-year veteran of Canadian advertising, he said the whole idea was a fabrication, and he had taken out a sworn affidavit to table at the meeting.

In it, he swore, "in my entire experience in the advertising communication craft I have never directly or indirectly seen, heard, read or been aware of the use of subliminal advertising techniques in advertising of the nature described by Dr. Key in (his) book."

Mr. Davis termed the Ontario health ministry's current campaign for moderation in drinking "good, sensible, socially responsible advertising that helps us to run our lives and to think for ourselves."

It was a much-needed campaign that addressed the crucial problem of alcoholism. It says "moderate drinkers think and act more clearly, more consistently . . . they do better work, are more highly motivated, and achieve greater success" (but he didn't say 'than whom'). "It also says in hard, clear terms, that drinking too much is dangerous."

The other two debaters waged the battle of statistics.

Hugh Edighoffer of Mitchell, Liberal MPP, cited the health, social and traffic costs of alcohol in Ontario, and compared the $260 million cost of alcohol abuse against the $369 million annual revenue the province gets from sales.

Since almost 90% of people now drink some, and there will always be some who never drink for moral, health or other reasons, the only way to increase sales is to increase the amount that people drink, he said.

Arthur T. Lennox, national director of advertising for Labatt's Breweries in London, Ont., put up a good fight on the figures front.

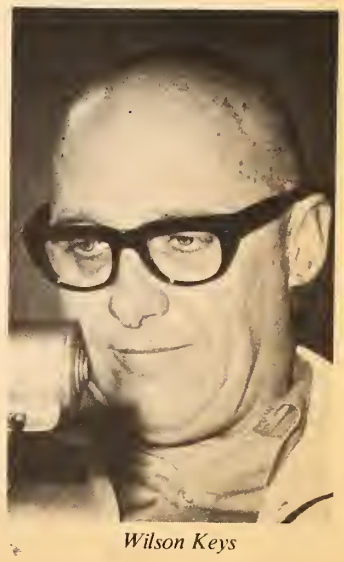
Between 1963 and 1973 in Ontario, beer consumption went up 15%; spirits, 40%, and wine, 93%. Beer is the most widely advertised on TV, liquor not at all, and wine infrequently.

In the same 10 years, Quebec and Ontario had the most TV and radio ads, but consumption of beer went up there 23 and 15% respectively, while it went up 108% in PEI, 85% in New Brunswick and 30% in British Columbia that ban TV commercials for beer.

Cigarette consumption has gone up since radio and TV ads were banned in 1971, another point in his contention that there is no proven relationship between advertising and consumption.

He said the 95% who drink

Arthur Lennox



Wilson Keys

sensibly should continue to do so, and the 5% who abuse alcohol need help now.

Advertising was aimed at "a better brand share than our opponents" and suggesting beer drinking in new situations is to say "at times we think they'd enjoy a lower alcohol beverage."

In response to a question, he didn't think labelling alcohol with a health warning, like cigarettes, would do any good, "but we're not against it."

The audience was asked to vote twice: once on the debate itself, regardless of beliefs; and once on personal opinions.

The debate vote was 68 to 32 in favor of the affirmative—all advertising should be banned in Canada.

In personal opinions, 75 thought all advertising should be banned, 10 thought there should be no ban, and 13 favored a partial ban or were undecided.

The debate was sponsored by Alcohol and Drug Concerns, Inc. of Toronto, and was broadcast live for two hours on a local radio station.

Rev. David Reeve, executive director of Concerns, said it was the first such town hall meeting held, and it would be assessed with a view to offering a similar program to other Ontario communities.

Alcoholics earning their keep: NIAAA reports

By HARVEY McCONNELL

MILWAUKEE—Increased earnings by patients who recover through programs supported by the National Institute of Alcohol Abuse and Alcoholism are greater than the cost to the American government to support them.

Dr. Morris Chafetz, NIAAA director, emphasized that the findings, which follow a two-year institute study, are still preliminary and he has yet to consult with his scientific advisers about them.

In an interview following an address to the annual forum of the National Council on Alcoholism held here, Dr. Chafetz said that "if the figures are correct" people in treatment programs have a high rate of recovery.

"This is measured in a number of variables like reduction in drinking, reduction of hospital use for any cause, earned income increases and more work days."

Dr. Chafetz added that while he has not been given the figures yet it also appears that "if people are caught early in their evidence of an alcohol problem a big proportion of them do drink socially. Although the data doesn't show it, I would guess that people at later stages are not as successful."

In his speech Dr. Chafetz said that NIAAA is going to practice what it preaches to develop a broader leadership base for the field.

"For example, we are going to be looking more and more in the future to State Formula Grants as a prime vehicle for alcoholism program funding." Collectively the states have come a long way since the Federal thrust on alcoholism began.

Area alcohol education and training programs being established around the country reflect the determination to decentralize. So is a new contract with NOA to establish field center to deliver information to where the users are rather than waiting for the users to come to programs.

Dr. Chafetz made it plain that with the present momentum of the alcoholism movement NIAAA "cannot and will not in the future try to be all things to all people." The agency will keep up its continuing commitments "but we will also be examining our grantees closely to be sure they are providing effective services for support given."

Other major forces in the field, must, like the NIAAA, give up some power.

Dr. Chafetz said: "We must all complement rather than compete as the movement continues to grow—or we will fall into the sorry old pattern of internecine warfare where the only casualties are millions of alcoholic people we are all trying to help.

... Still a long way to go

MILWAUKEE—Much more information and training in alcoholism is needed in the community, especially, according to Dr. David Pittman, among "the gatekeepers of funds and service allocations."

Although current social attitudes and priorities towards alcoholism are changing, there is still a long way to go, he added, in a review of the situation today in Canada, America and Mexico given to the annual forum of the National Council on Alcoholism here.

Dr. Pittman, director of the Social Science Institute, Washington University, St. Louis, said: "There is probably too great a reliance on the part of North Americans on drugs for changing their states of mind and feeling tone.

"The prevalence of alcoholism and drug abuse in Western society makes these conditions among the major medical and social problems of this century."

Alcohol is the most widely abused drug in North America "and numerically it is the most abused drug by the population in the United States, despite the mass media's attention to marijuana or heroin," he said.

Dr. Pittman questioned the main contentions that alcoholism is either a symptom of an underlying mental condition or that it is a chronic illness.

"If alcoholism is caused by underlying psychopathology, then a resolution of this conflict by the patient in a therapeutic context should allow the individual with his revised personality to return to normal or social drinking.

"This, as we know, rarely occurs; therefore we should critically evaluate the merit of this unadulterated psychoanalytic position in reference to our conception of alcoholism."

The disease concept means that doctors like general practitioners begin to assume more responsibility for care instead of providing blanket psychiatric referrals and hospital staff, who always deal with chronic disease, can better accept the relapses of alcoholics.

Dr. Pittman added: "Despite the pervasiveness of the disease and symptom viewpoints toward alcoholism, we should not overlook the possibility of other orientations towards this condition. For example, alcoholism may be a secondary disorder resulting from the convergence of an array of intrapsychial tensions, normative orientations towards drinking and alternative mechanisms of tension reduction."

The last decade has seen a massive social movement to redefine the position of the alcoholic and alcoholism within the health delivery system. Despite this there are still attitudes of negativism and pessimism towards the provision of services for alcoholics.

"Alcoholics and the reactions of the society to them and the organizations working in the field closely resemble the minority group status syndrome. Alcoholics, like many minority group members, know at firsthand the segregation procedures."

David Pittman

Ontario legislation pending

More drinking in more places

By TOBY BARRETT

TORONTO—Ontario's new proposed liquor legislation revising the Liquor Control Act and the Liquor Licence Act has been sharply criticized by Alcohol and Drug Concerns Inc., a voluntary citizen's organization.

"While it is the stated intention of the new legislation to reject foreign drinking standards, it in effect provides for an extension of Continental drinking practices by allowing drinking on more occasions and in more places," said Rev. David Reeve, Executive Director of ADC.

"The new cabaret licence and recreational club licence open the way for growing consumption and an overall increase in abusive practices."

Mr. Reeve said recreational facilities and clubs are already areas of high level drinking on premises which are not easily controlled or inspected.

"In addition, it equates sports fun and youth with drinking," he added.

In the past, golf, skiing and curling clubs could obtain a licence only in conjunction with a dining lounge. Under the proposed law, racquet clubs would be added to the list of recreational clubs, and licences would be issued without requiring a dining room or that food be served.

The cabaret licence would allow clubs whose prime function is live entertainment to sell less food than is now required. The proprietor would have to receive only 30% of revenue from food, compared to the current 50%.

In a letter to Ontario Premier William Davis, ADC Board of Directors request a meeting with the Cabinet to air their views on the proposed Bills.

The Board has also requested representation on two advisory committees to Sidney Handleman, Minister of Consumer and Commercial Relations. The Board also requests consideration of "similar representative groups, including the medical profession, religious bodies, responsible youth agencies and groups otherwise concerned with the health and well-being of our citizenry."

When introducing the Bills, Mr. Handleman announced establishment of the two committees "to help monitor continuing changes in social attitudes and ensure that we remain responsive to all viewpoints on alcohol consumption. One committee will deal with special occasion permits and the other with concerns on overall liquor policy.

Members will be appointed by the Ministry of Consumer and Commercial Relations in consultation with the chairmen of the LCBO and LLBO.

Welcoming these advisory committees as a mechanism that will "open the door to what was a closed process and allow for some public input," Mr. Reeve stressed the importance of representation.

David Reeve

"I would not want them to be a bunch of ex-politicians and bagmen, not genuinely representative of communities and citizens who are concerned."

Other plans for public participation include a newly-created tribunal, consisting of up to seven members, to hear appeals on decisions of the LLBO and public hearings for the granting of new licences.

Reeve reiterated his organization's stand of two years ago. It called for the LCBO to be under the jurisdiction of the Secretariat for Social Development (now called the Social Development Policy Field). In this way humanitarian concern rather than business enterprise would be given full weight and consideration, he said.

"In its annual report, the LCBO always reads like a market and profit oriented enterprise and not as a control agency. Sales are up, revenue is up . . . but social costs are ignored—just as they are ignored in this new legislation.

"It's in Social Development, the Ministry of Health and the Ministry of Community and Social Services where the social costs of alcoholism are felt. This is where the control should lie."

Under the proposed legislation, the LCBO will continue to manage the distribution and sale of liquor through its 530 outlets across the province. However, the LLBO would assume all licensing and regulatory functions, some of which had previously been exercised by the LCBO.

Recent press coverage has highlighted the "Milk in Bars' aspect of the legislation, designed to encourage the serving of alternative beverages to alcohol in licenced premises.

Mr. Reeve pointed out that his organization's brief requested that this be made mandatory two years ago for the benefit of the non-drinker, 'the person who is driving; the diabetic or the salesman who must pursue business where there is a high expectation of drinking with customers.'

"Unfortunately the media is subject to lobbying by the beverage alcohol industry and thus the 'Milk in Bars' was played up and blown out of proportion.

"Perhaps there should be a greater emphasis on people being able to comfortably, and without embarrassment, order drinks like lemonade or fruit punch—the so-called 'Sweet Marys' or 'Shirley Temples,' he said. "For example, members of AA would like to participate in the conversation and comaraderie of a pub without being obligated to drink alcohol."

For the first time, the legislation makes it clear that a parent or guardian can legally give liquor to a person under 18 years of age in his own residence.

The original act, passed about 30 years ago, provides for a fine of not more than $1,000 and a jail sentence of not more than three months for persons who supply alcoholic beverages to minors.

Bartenders dish out more than cocktails

By DAVID ZIMMERMAN

RACINE, WISC.—Bartenders in this industrial city are being trained to be mental health referral agents. A dozen of them who participated in a 15-hour training program last June thus far are known to have made eight referrals, and the program is judged by the sponsoring agency, the Mental Health Association of Racine County, Inc., to be an enormous success.

"Its been successful beyond our wildest dreams," says Mrs. Ruth Weyland, the Association's Executive Director.

Mrs. Weyland bases her estimate on the more than one hundred "requests coming in to our office for information, and the appeal that it had to the media". Stories about the program have appeared in the **New York Times**, and have been carried by wire services, TV, and radio stations.

The bartenders have referred three couples for marital counselling. They also had referred three other customers for budgetary counselling.

The most dramatic referral was made by Mrs. LaVerne Kowalski, a tavern owner, who spotted a former alcoholic as he entered her establishment to take his first drink. As part of the training program, she had visited the hospital where he had been treated for his alcoholism, and with its image clearly in mind, according to Mrs. Weyland, she sat down and had a long talk with the man. She persuaded him not to take that first drink. Mrs. Weyland quotes the man as having told Mrs. Kowlaski:

"You know what I came in here for! You prevented me from doing it again."

The training sessions were held on Monday nights—the slowest night of the week in taverns—and included talks by police officials, lawyers, mental health workers, and specialist in outreach referral programs. Diplomas were handed out to participants at the end of the program.

The program met some initial hostility. "A lot of our tavern owners thought it would be an alcoholic witchhunt," Mrs. Weyland said. "It was not an easy program to sell."

What made it attractive to the barkeepers, she said, was the explanation that "it has been their traditional role to be good listeners, to listen to people with a number of problems, and, very often, to suggest some help."

The barkeepers were told, she said, that the program simply aimed to train them to do what they do traditionally—to listen—a little bit better. They were told they would be familiarized with social resources in the community to which their patrons might be referred.

In setting up a referral program, Mrs. Weyland says, it is important to impress upon bartenders that they are not counsellors, but, rather, are listeners and referral agents. At the end of the course, she said, they should be given a list of community agencies and their telephone numbers.

Olympics '76

(Continued from page 1)

Other drugs forbidden by the IOC include the amphetamines and related compounds, miscellaneous central nervous system stimulants, sympathomimetic amines and narcotic analgesics (The Journal, Nov. 1, 1974).

Adequate screening for all drugs will require the largest deployment of medical staff in Olympics history. Some 250 doctors will head a staff of some 2,000 people.

A collection station for urine samples will be set up at each competition site. First-aid stations at each venue will be in the ratio of one for every 1,000 spectators.

Blood sampling will also be performed to determine possible alcohol consumption by athletes who desire a depressant to steady their nerves. The blood analysis must show a zero reading.

Asked about the possible use of hypnosis, Col. Letourneau said the IOC has not taken a stand on this "at this point in time" and they do not think that it will be necessary to do so.

As for other Olympic developments, Lord Killanin, the Irish peer who is president of IOC, recently toured all Olympic construction sites and pronounced himself content with progress.

Doctors aim to CURB barbiturates

LONDON: A growing chorus of concern from enlightened doctors has led to the formation of CURB—the Campaign on the Use and Restriction of Barbiturates.

Its headquarters will be at British Medical Association House and staffed initially by a co-ordinator and an assistant.

A clinical pharmacologist, Dr. Ken Hunter, is expected to be appointed co-ordinator.

Barbiturate prescribing is on the decline in Britain with the introduction of new sedative drugs, but they still represent a major abuse problem.

Initially, CURB will act as an information service for doctors and it will also help plan a major symposium on barbiturates. This is due to take place at the Royal College of Physicians in September.

It is hoped that despite its modest budget CURB will be able to generate wide publicity to educate pharmacists and the general public about the dangers of barbiturate abuse. This effort will be backed by the pharmaceutical industry which has become increasingly sensitive to criticism about the availability of dangerous drugs.

Pregnant women hide drinking from doctors

MOST PREGNANT women are reluctant to tell their obstetricians about their true drinking habits, a survey by Dr. Ruth Little of Johns Hopkins University has revealed.

Heavy drinkers underestimated, and infrequent drinkers overestimated their behavior to the obstetricians, who failed to uncover almost all of the heavy drinkers later found by independent interview.

Conversely, most of the women when questioned about smoking habits gave the same answers to both obstetrician and interviewer.

Dr. Little said 67 women were questioned from a large sample of paying members of a health maintenance organization in Seattle, Washington. Most were middle-class white women.

All of the women attended two obstetricians who regularly questioned patients about their drinking habits.

None of the women gave indications of heavy drinking to the obstetricians and only two were considered by them to be moderate drinkers. However, 12 of the patients were considered heavy or moderate drinkers by the interviewers.

At the other end of the scale, women considered light drinkers by the obstetricians were rated infrequent drinkers by the interviewers.

Dr. Little said the data suggests "that the reports of drinking to the physician were of limited usefulness since all women tended to declare similar quantities."

She said that because of the mantle of omnipotence that the doctor bears "their patients may be reluctant to disclose the full extent of their behavior. In general, the greater the drinking, the more defensive the patient and the less accurate the reporting.

"Thus, the person whose drinking may be doing the greatest harm is the least likely to report it."

A recognized disorder

Fetal alcohol syndrome

UNIVERSITY OF Washington doctors now rank the fetal alcohol syndrome third in their experience of recognized disorders featuring mental deficiency. Only Down's syndrome and neural tube defect cause more cases.

Dr. David Smith said most of their 41 cases have been evaluated in the past two years. They are aware also of a minimum of seven cases in Vancouver, eight in San Diego, six in Anchorage and San Francisco, and five in Sacramento.

Direct proof is lacking but ethanol is the probable cause of the adverse effects on morphogenesis that constitutes the syndrome. Ethanol readily crosses the placenta and gains access to fetal tissue.

He said one baby had "the smell of alcohol on his breath at the time of birth and the amniotic fluid from another such baby had the odor of ethanol".

The syndrome has been found only in a proportion of the offspring of alcoholic women.

He said the syndrome has not been reported from certain areas because it has not been recognized. In large cities many pediatricians are knowledgeable about the situation.

Dr. Smith said chronic alcoholic women should either be put on contraception or be offered termination if they conceive.

Dr. Ann Streissguth said that following psychological studies of children with the syndrome she and colleagues concluded maternal alcoholism of long duration can have a very deleterious effect on the intellectual development of the offspring of lower class women.

Even when maternal education and other relative variables were similar the children of chronic alcoholic women had significantly lower intelligence at age seven.

Seventy-five per cent of the offspring of lower class alcoholic women had borderline to moderate mental retardation. On the same scales some children of alcoholic mothers did fall into the normal range.

Clinical studies suggest the primary cause of the intellectual defecit in the syndrome is a result of insult to the brain in utero.

Dr. Streissguth said children identified at birth as having the syndrome, and who were raised in excellent foster homes, were among the most retarded subjects.

The Woman Alcoholic received much attention at the recent meeting of the National Council on Alcoholism, Milwaukee, Wisconsin. Conference coverage by HARVEY McCONNELL will be continued in the next issue of The Journal.

Alcohol . . . and Black women

A PAUCITY of research, coupled with a number of popular myths makes it is impossible to generalize about the black female alcohol abuser.

In truth, "there is no such woman as The Black Woman," declared Ms. Jackie Gaines, alcoholism coordinator with the division of alcoholism in Boston.

Black women come from a variety of economic and educational levels and only share in common "the effects of oppression that we have experienced, not only because we are black but also because we are female."

The most detrimental myths are that the black family is disintergrating because a large number of households are headed by women who are domineering, emasculate their men, and who are better off economically than their male counterparts.

Ms. Gaines said in the vast literature on alcoholism "I have yet to see a report on alcoholism and black women which goes beyond a brief statistical summary or mere conjecture". Major studies of female alcoholism had very few black women in the samples.

Any answer lies only in future research.

Until then Ms. Gaines suggests treatment staff must be sensitive to their own attitudes towards black women. Once they understand the special characteristics of black women they can help them to fulfill their role as women as well as work with their alcohol-related problems.

Alcoholism treatment agencies need to make greater efforts to reach out to health and social agencies, such as maternal and child health clinics, which are heavily utilized by black women, she said.

Treatment agencies must recognize the special needs of women, particularly black women, and design programs to meet them, such as baby-sitting or day care centres so the mother may more freely attend treatment programs.

Ms. Gaines said: "As black women continue the process of redefining themselves; as clinicians, researchers and others accept this redefinition, it will encourage black women to clarify their attitudes about alcohol use and abuse.

"We should expect much healthier drinking practices by future black women and this should improve the functioning of the entire black community."

Women "catch" alcoholism

DEPRESSION, PROMISCUITY, and not going to work are three of the labels erroneously associated with women and alcoholism, charges Professor Edith Gomberg of the University of Michigan.

Nor is getting out of the home and taking a job the cure-all, she said.

A high incidence of depression is found in a number of studies of women alcoholics—but statistics in general show that women manifest more depression than men. This also applies to suicide attempts, says Professor Gomberg of the school of social work. There is no substance to the promiscuity label either. "Maybe we're blaming alcohol for a lot of our own foolishness."

As for the argument that if women left home and took jobs the number of women alcoholics would drop it ignores the fact that a high rate of alcoholism is found among women in industry.

What women do more than men is copy their spouses' drinking habits and many of them "catch" alcoholism this way.

Professor Gomberg attacked the double standard accepted by society that a woman drunk is labelled abnormal but a male drunk is condoned. Regarding recovery, she said current studies show there is no difference in rates between men and women.

Handicapped children

TWO WOMEN who gave birth to six children, including one set of twins, all by a different father, lead Boston University researchers Drs. Henry Rosett and Eileen Ouellette to believe that the fetal alcohol syndrome is not genetic.

One of the women gave birth to a normal child before starting to drink. Two years after becoming an alcoholic she had a second child, who at age four, functions at the level of a three-year-old.

Her third child, now one year, is grossly retarded mentally.

The second woman also has a normal child before she started drinking. Twins were born after she had been drinking for a while and both are moderately abnormal.

Her third child is extremely handicapped.

Dr. Ouellette said: "We are extremely disturbed by the fact each successive child born to these two women seems to be more disabled. This is even more disturbing than the risk in general to chronic alcoholic women.

Smaller brain weight at birth—and the potential risk of subsequent neurologic impairment—was found in the nine infants with the syndrome they have studied. Still to be explored are possible inter-relationships between alcohol and malnutrition, smoking, drug abuse, vitamin deficiency, hypoglycemia and trace mental deficiency.

Dr. Ouellette said the severely affected infant is probably at the bottom of a bell-shaped curve covering a spectrum of abnormalities.

HOSPITAL A SALVATION

OLDER WOMEN alcoholics find the "caring and sharing" of hospital inpatient treatment the cornerstone for their eventual recovery, in the experience of Ms. Mary Ann Mills, in-patient counsellor at DePaul Hospital.

Widows, divorcees, or those who have retired, and all living alone, "come to us very much afraid and very isolated. Most of these women really feel lost, helpless and hopeless," she said.

A large number either have no family ties or have been abandoned by their children. Extreme depression is common.

But in the hospital, where they find people who care and are willing to listen—"and this is one of the most important things, just listening"—they begin to feel less lost and helpless and begin to care about themselves again. They begin to hope.

Behavior related to hormone level

SEX HORMONE levels may be related to the behavioral effects of alcohol, researchers at the University of Oklohama suggest following a study of 20 women students tested at two-week intervals.

Dr. Ben Jones, PhD, said the effects of alcohol on memory, at different times in the menstrual cycle, and on performance, were measured against the performance of 10 male students.

Women became more intoxicated than males on the equivalent dose of alcohol, particularly if they drank during the premenstrual phase of their cycle. It also appeared that women were more impaired than men by alcohol on tasks that require an inhibition or delay of response.

Women obtained a significantly higher peak blood alcohol level than men on the equivalent dose of alcohol.

Women denied treatment

WOMEN ALCOHOLICS seeking community inpatient treatment in the five boroughs of New York often find they cannot obtain facilities similar to those available to men.

There are beds in a rehabilitation centre or a halfway house "but very often she is denied treatment in her own community," said Ms. Mary Bernstein, deputy director of information and referral service, New York City Affiliates.

Added to this is a lack of social support systems. "If she has children and wants to go into care what kind of support system does the borough provide for her? Nothing."

Ms. Bernstein said that when she started her research "it never occurred to me that I would have to collect all the data about how many male beds existed and how many female beds existed in facilities that are funded by the city and state of New York. But I did."

She does not believe the lack of facilities for women is deliberate. "Some people, but not the majority, have difficulty in dealing with women in treatment and therefore prefer to avoid that area."

Growth stifled

A CONSISTENT pattern of severe postnatal growth deficiency has been found by Dr. Kenneth Jones, of the University of California (San Diego), in children with the fetal alcohol syndrome.

In those followed beyond 12 months, the average linear growth rate was 65% of normal and average rate of weight gain only 38% of normal, despite the fact many were put into hospital repeatedly and adequate caloric intake documented.

Dr. Jones said the most striking case was a native American child who at seven months had a height and weight that were in the 50th percentile for 35 weeks gestation.

In the 41 cases studied so far, intelligence tests ranged from below 50 to a high of 83 and an average of 63.

Significant brain anomalies were found in the only autopsy he knows to have been carried out on a child with the syndrome.

Dr. Jones said: "We do not know the critical stage during gestation or the critical amount of alcohol necessary to result in an infant with the fetal alcohol syndrome." The total spectrum of the disorder has not been fully set forth.

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A call for structure

THE ANNOUNCEMENT that planning has already begun for the 1976 National Drug Abuse Conference is welcomed indeed. There has been much concern expressed about the lack of organization witnessed in New Orleans, and it seems that if this kind of event is to provide the information and substance that makes attendance worthwhile, then some professional approach to its construction is essential.

Because of the multidisciplinary nature of the drug abuse field, tnere has quite naturally been a tendency to keep proceedings flexible, general, to keep away from the elitism that characterizes many scientific "information factories" that pass as conferences.

There is something to be said for allowing conferences to be "sharing" experiences rather than paper retrieval contests.

But there are risks in going too far, in denigrating structure, form, and organization.

The scientific conference format may be subject to a lot of abuse. Certainly, it is frustrating to try to cope with a rapid fire of scientific papers as they reverberate in meeting rooms miles apart.

But the didactic format is not without value. The "paper" lecture does allow a most economic form for the transmittal of a lot of information in a short time.

By choosing to emphasize this kind of substance in the next drug abuse conference, its organizers seem to be making a comment not only about the specific 1976 meeting, but about the field itself.

It's quite natural that there would be some antipathy—or at least suspicion—between the hard core, research-oriented scientist and the street-oriented counsellor. It is sometimes quite difficult for a non-scientist to see the relevance in a rarified discussion about the chemical properties of antagonists as they are manifest in rats.

But there should be a continuum of activity at work and that continuum involves the scientist, the street worker, the institutional worker, and the communicator. Blending all their diverse interests and techniques is really the task that the organizers of any successful conference on drugs must achieve.

That task is made much more difficult when the responsibility for organization rotates from area to area each year. It seems there would be considerable value, and cost-effectiveness, if a permanent secretariat was established to handle not only the organization of this and other satellite conferences, as well as to provide a national focus for other activities involving this field.

Why, for example, should the transmission of information concerning drug abuse treatment, research, and education exist only on the periphery of other organizations?

Why, for example, should the best research papers on drug and alcohol issues be presented primarily at the American Psychiatric Association meetings, or at meetings of pharmacologists, health educators, psychologists?

It is obvious to see why speakers want to present at these meetings . . . they have stability, they elicit professional respect, they have a sound, reliable recording system by which the papers work their way into the literature.

Obviously, the planners of the 1976 drug abuse conference see some value in mobilizing this kind of information flow directly to drug abuse workers.

... for statistics freaks

WHATEVER HAPPENED to the drug problem?

Well, if your definition of "problem" is simply equated with an increase in drug use, then the drug problem of the 1960s has reached epidemic proportions.

But whereas a few convictions for cannabis use in 1965 caused panic in the streets, new figures released by federal authorities in Ottawa will probably be received by a big yawn.

For history and/or statistics freaks, here's a decade look-back at Canada's drug problem, courtesy of the federal Bureau of Dangerous Drugs.

In the decade since 1964, marijuana and hashish convictions in Canada rocketed from a barely-significant 28 convictions in 1964 to a whopping 29,067 convictions in 1974.

That's an increase fitting for the Guiness Book of Records: 103. 810.71% (thanks to the wonder of electronic calculators).

During the same nostalgic, drug-filled decade, heroin convictions increased by 193%, from 272 in 1964 to 788 in 1974.

Curiously enough, heroin convictions reached a high of 1,290 in 1973, and the number of convictions actually dropped by 38% in 1974 compared to the previous year.

Cannabis convictions, by the same comparison, rose 46% between 1973 and 1974, from 19,929 to 29,067.

Convictions for methadone abuse increased 2,400% from 1 to 24 during the drug decade, reaching a high of 82 convictions in 1971.

Cocaine, the "wonder drug" of the last couple of years, didn't register in the Canadian conviction columns until 1965 and didn't really become a factor until 1970, when 12 convictions were registered.

By 1974, the number had jumped to 237, or 93% higher than the 123 convictions in 1973.

The hallucinogens like LSD and MDA were not known until the sensuous 70s, at least in terms of the conviction book. The high for LSD came in 1970 and 1971—1,558 convictions, compared to 1,482 in 1974.

The high for MDA was in 1973; 792 convictions compared to 501 in 1974.

And on and on and on.

Yep, we've come a long way.

"That's quite acceptable, Hughie—but we need a note from Mummy confirming yesterday you had a hangover . . . "

Letters to the Editor

Smoking twins

Sir:
In **The Journal** (May 1), there is an article on page 1 dealing with smoking and the research conducted by Dr. Colin Woolf, a professor of medicine at the University of Toronto. The article mentions that the research team is looking for idential twins that smoke.

I happen to know such a couple and would ask you to pass their names to Dr. Woolf's team as they may be of some use to them.

A. K. Swainson
Lieutenant-Colonel
Assistant Judge Advocate General
Department of National Defence
Northern Ontario Region
Air Defence Command
Hornell Heights, Ontario

Incest doubt

Sir:
Studies by the Maryland Drug Abuse Research and Treatment Foundation, Inc., have found six incidents relating to incestuous relationships (**The Journal**, May 1, 1975).

Each of these "incidents" were thoroughly explored and found, in each case, to be a product of a type of fantasy symptomatic of the retrospective falsification of the Cannabis Syndrome.

This ability to change the past to fill a current psychic need should have been recognized by Dr. Densen-Gerber, particularly since probably all those alleging such previous relationships were or had been marijuana users.

The operation of this revisionistic, ego-protective thought disorder is fascinating.

A. V. Millman
Director, M-DART
Baltimore, Maryland

THE JOURNAL welcomes letters to the editor for publication. Letters, which must be signed and kept as concise as possible, should be addressed to The Editor, The Journal, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto M5S 2S1, Ontario.

MEMBERS OF THE U.S. Senate Sub-committee on Alcoholism and Narcotics are now preparing a bill to create a new executive office for drug abuse. This new office, somewhat similar in language to the Drug Abuse and Treatment Act that created SAODAP, is different only in that the office will govern drug abuse policy.

I am looking forward to this new office being innovative and unique in the sense that new approaches to the century old drug abuse problem will not only be devised, but implemented.

The question of what happens in the future to established drug abuse programs remains unanswered. Unofficial plans indicate that treatment programs as we know them today will be phased out, and treatment facilities will be reallocated based on preformulated information that would identify types of programs, size and treatment offered, as well as future budgets to combat "micro" or "macro-epidemics" on an "epidemic intervention"

Backgrounder

By MILAN KORCOK

Prescription drugs (part two)

MILLIONS OF doses of psychotropic drugs are prescribed each year in North America.

Most people who take these drugs are convinced of their benefits.

In fact, one study has shown that 75% of the users of prescribed psychotherapeutics will testify the drug helped them "a great deal" or at least "quite a bit."

But in the midst of this overwhelming use, and substantial endorsement, there is growing evidence that *abuse* of drugs other than alcohol or heroin is growing at an alarming rate.

Polydrug abuse—the mid-seventies term for misuse of a galaxy of non-opiate, non-alcohol drugs—finds its victims at many levels of society.

There are those who get their drugs through physicians' prescription but use them in excess or out of the stated regimen; those who get their drugs without medical prescription: those who use drugs primarily for recreational or social purposes. And there are some in each of these groups who suffer, or who benefit, by this process.

There are also those who follow the rules and still run into trouble.

One continuing study of outpatient prescriptions at the UCLA medical centre shows that over a four-year period, approximately 30% to 40% of prescribed barbiturates (secobarbital, pentobarbital, and amobarbitol) were dispensed for unsafe, excessively high dosage levels.

This indiscriminate dispensing of barbiturates is unnerving since data from some pilot polydrug detoxification programs shows that 30% to 40% of people admitted list barbiturates and sedatives as their primary drug of abuse.

The stereotype of the pill freak as predominantly a speed user remains prevalent in much of the media, but the fact is that barbiturates claim a heavier toll than all other classes of drugs.

Barbiturate consumption is the most frequent means of committing suicide, and the most prevalent route to accidental death by drug overdose.

In one study of almost 1,900 arrested people in six U.S. cities, 922 individuals were found to be current users of barbiturates, and, throughout the country as a whole, barbiturates were the third most widespread drugs used by the arrested persons—following marijuana and heroin.

Assessments of the "walking wounded," those who have in one way or another fallen victim to "polydrug abuse" are just now coming to light. The revelations are disturbing.

Data from hospital emergency rooms, inpatient facilities and crisis centres in the United States show up very consistent age, sex, and race patterns among drug users requiring clinical help.

Blacks, for example, who make up only about 12% of the national population between the ages of 15 and 34 years, make up 68% of the emergencies related to opiates and cocaine; women present almost twice as frequently as men for emergencies related to sedatives, tranquillizers, and stimulants.

And while more than 80% of hallucinogen and stimulant users who have medical emergencies are under 30 years, more than 35% of the sedative and tranquillizer users are over 30.

A recently-completed composite survey of 12,000 adults done under sponsorship of the National Institute on Drug Abuse showed that of the 9% of individuals who had used minor tranquillizers in the past six months, more than a quarter did so non-medically—i.e. either without a prescription or outside of the directed regimen—and about one fifth of these did so three to five times a week.

In extrapolating data from these studies, NIDA could show that almost 5% of the population they surveyed—a population they feel is representative of the nation as a whole—use non-opiate drugs outside of a medical context. And, they project that since there are 150 million people in the country 14 years of age or older, there may be as many as 7½ million people in the United States who use non-opiates non-medically.

In conventional medical terms, this kind of self-medication is frowned upon, labelled "bad" because it is not the socially-sanctioned way to do things.

But separating good and bad is not that simple.

Dr. Donald Wesson, psychiatrist at the Haight Ashbury Free Medical Clinic, writes that "while almost everyone would agree that high dose intravenous amphetamine use or injection of intoxicating doses of dissolved barbiturates intended for oral use would constitute abuse of these drugs, there is much disagreement on how to label the individual who self-medicates himself with commonly used therapeutic doses of amphetamines or barbiturates, or the individual who obtains drugs by prescription but takes more than the amount prescribed."

Wesson argues that there are, in fact, people who take drugs non-medically who are indeed ill and who do manage to relieve their uncomfortable symptoms. It would be highly questionable to automatically lump these individuals into the poorly-defined category of drug "abusers," suggests Wesson.

Speaking on behalf of his co-authors in this report, (Dr. George Gay, and Dr. David Smith, of the HAFMC), Wesson says: "We question the belief that drug-taking behavior per se is illness. It appears to us very arbitrary to define taking certain psychoactive drugs as illness while giving social sanction to others. Do we define the social use of alcohol as illness because of medical sequellae observed in the chronic alcoholic?"

The conventional definition of use and abuse is bound to remain obscure for some time. Perhaps what really matters and needs to be gauged is how many drug users require clinical intervention for health reasons?

Dr. John Benvenuto, consultant to the division of resource development in the National Institute on Drug Abuse, recently reported some findings concerning the federally-funded polydrug pilot projects established in 11 communities across the United States.

The projects were primarily research-oriented, though they obviously filled a service need for what appear to be growing numbers of polydrug users requiring some kind of help.

Nearly 1,200 patients were studied in the polydrug programs—a great many of whom exhibited a wide array of social, personal, and psychological problems characterized as "suprisingly severe."

Despite the fact the polydrug abusers had achieved a normal level of education, more than 75% were unemployed, and of those who were working, many had erratic work histories. Only 47% of this population had ever been married, and 56% of these were currently divorced or separated.

More than half the patients had experienced prior treatment in either a drug abuse or psychiatric program, and the entire population averaged two arrests each over the one-year period prior to survey.

Dr. Benvenuto notes that even though the large majority of client-patients had normal IQ scores, most had severe levels of psychopathology and personal dysfunction—about the same level one would expect among a hospitalized psychiatric population.

The patients suffered from significant depression, had difficulties in personal relations, felt isolated, had few interests, and tended to have low self esteem.

The patients accepted into the 11 polydrug programs are a small sample, but various scientific groups believe they may reflect some 2 to 2½ million people in the U.S. whose non-opiate, non-alcohol drug use is causing them significant health damage requiring some kind of clinical intervention.

The tragedy is that treatment technology for non-opiate abusers who need it is primitive.

Compared to the heroin addict, the individual swallowing large quantities of barbiturates and alcohol and needing treatment must feel he has been left out in the cold.

By Wayne Howell

THE QUESTION of 'tolerance' to marijuana is still a subject of debate among scientists. But there can no longer be any doubt that the so called 'marijuana intolerance syndrome' has become a demonstrable clinical entity. Unimagined a decade ago, almost unheard of five years ago, it is now showing up with increasing frequency.

A person manifesting signs of marijuana intolerance syndrome (MIS) exhibits certain identifiable behavior characteristics. There is, for instance, the curious 'amotivational state'. Persons afflicted with MIS lack the motivation to become involved in cocktail party conversations about the socio-political-philosophical ramifications of marijuana use.

Is marijuana use a reaction to the competitive nature of capitalism?

Is it a protest against the values of a bourgeois society?

Is it a manifestation of social alienation, the dreaded anomie of the existentialist philosophers? Has marijuana killed Consciousness II?

All the great pot-boiling questions of the late sixties leave them cold.

Even the Great Ironies (the suppression of marijuana, a relatively harmless drug vs. the tolerance of alcohol and other dangerous psychoactive substances etc.) fail to excite them any more. Aimless drifters, passive and indifferent, they are apt to be found in a corner discussing the weather or the Stanley Cup playoffs.

Persons showing signs of the amotivational state also appear to suffer periods of memory loss.

Take the case of persons who rushed out to buy newstand copies of Time Magazine's great 1969 scoop-issue on the LeDain Interim Report rather than wait until their subscription copies arrived by mail two days later.

Many of these persons completely forgot to turn on their television sets to catch the Senate Hearings on cannabis legislation six years later. They had planned to watch the proceedings but when the time came, it slipped their minds. Afterwards they did not feel regret that they had missed this latest round in the Great Interminable Marijuana Debate. In fact, they were apathetic.

One curious feature of the marijuana intolerance syndrome is that it leads to emotional lability and inappropriate laughter.

When MIS victims read the writings of the great pot-proselytizing prophets of the late sixties, they are apt to break into fits of uncontrollable giggling.

Timothy Leary's 1966 assertion that 'rock musicians and dope dealers are bringing about the great evolution of a new age', never fails to break them up.

Paradoxically, they can become quite sullen, morose, and even hostile, if they are asked to read just one more feature article in a newspaper about the marijuana 'problem'.

The causes of marijuana intolerance syndrome have yet to be discovered. Various etiologies have been proposed. The one hypothesis that shows the most promise is the theory that the issue of marijuana has become for a great many people, a colossal bore.

st Book Conrad Mauge

ncept.

Other alternative options for e future of drug abuse programs ve been outlined in the "Fed-al Strategy for Drug Abuse and rug Traffic Prevention" by the resident's Strategy Council. heir major suggestions are as llows:

1) An existing drug abuse amework could be reduced in ze (gradually), leaving in operaon those programs having the ost demonstrable impact on the ogram.

2) The framework could be conrted for use in combating other ug-related health problems such alcoholism, and/or

3) Because drug use problems ten overlap with problems of dequency, those resources not eeded for drug problems could be ed in the continuing effort to reice crime through rehabilitaon; it is conceivable that eventuly each of these approaches ould be utilized to some extent.

I offer a fourth alternative.

It is my contention that a transr of funds and manpower from e highly specialized drug field to program of *comprehensive community service* will serve to remedy the drug abuse problem by helping eliminate its underlying causes.

I will now discuss existing problems in the provision of medical, legal, educational, and job development services to urban ghetto residents.

Medical Services—the most prohibitive factor is the cost of care. The specialization of physicians and their movement out of disadvantage areas also contributes to the overall problem.

When services are located near the disadvantaged community, residents often feel, and justifiably so, that they receive unfair or unsympathetic treatment from medical institutions. The most common and inexcusable complaint is levelled against outpatient hospital care, which is reported to be impersonal and frequently demeaning to the patient.

Job Development—this area encompasses job counselling, job training, job placement. Within the disadvantaged sectors, the major stumbling blocks encountered are: lack of knowledge, as to how and where to seek help: discrimination against females, minorities, and persons who have criminal records; and the lack of employable skills, both academic and technical, on the part of individuals.

Nationally, the unemployment rate has reached an all-time high. However, according to Bureau of Census figures, the rate of unemployment for minority groups is not the nationally quoted 8-9%; rather for this particular population, the percentage ranges from 27% to 38%. The difficulties faced by disadvantaged persons attempting to enter the job market are numerous and long standing;

- The number of semi-skilled and unskilled occupations has been greatly diminished;
- minority group members continue to be the last hired and first fired;
- the problem of obtaining adequate training with the assurance of employment has become hard to secure;
- blacks especially are affected by early job obsolescense;
- several problems are superimposed on the situation by the seekers themselves—

Legal services—problems surrounding this area are numerous and formidable. Most outstanding is the almost total lack of knowledge regarding one's civil rights and what actions can be taken should those rights be violated. The next obstacle is the heavy cost factor of retaining an independent, private attorney. Free legal services or advice is not available to the individual until *after* he or she has been arrested, arraigned, and by court direction, placed in the hands of an overworked public defender.

Additional problems arise when minority group members submit to police intimidation, or due to their naivete in dealing with the law and/or the courts, unwittingly allow themselves to be taken advantage of during legal proceedings. Underlying all of these factors is an unspoken distrust of the machinations of government and the legal system coupled with a fear of reprisal for bucking the power structure.

Education—underlying all of the pathologies previously cited is the key issue of education. The problems encountered by the individual run the gamut from poor accessibility to institutions to total alienation from the existing system.

A final point deserves attention—the cry for diversified information pertaining to programs, facility locations benefits, rights, activities, etc. *must* be answered. The converted drug abuse program as a central community resource, could provide a needed service to that community by offering itself as a clearinghouse of information. The role of communications conduit between the larger society and its handicapped sectors may well prove to be the most valuable service of all to those individuals attempting to break the cycles of poverty and miseducation.

400 disabled produce enough umbrellas for the whole country - Ethiopia

ILO instructor assists blind young man at umbrella factory

The handicapped

By DAVID ERLICH

GENEVA—To be addicted is to be "handicapped" according to officials of the Vocational Rehabilitation Unit of the International Labor Organization.

Thus, drug dependence has been added to the group of major physical and mental handicaps—notably blindness, deafness, mental illness and retardation—which the ILO considers part of its mandate.

The agency has led in this critical field—an estimated 400 million people are handicapped—since its birth after World War I when it pleaded for special legislation, training, and employment opportunities for disabled former soldiers.

The extension of the program to embrace the addicted was stimulated by an expanded United Nations effort which relies on interagency cooperation. It will be aimed primarily at developing countries where the problem of stabilizing and rehabilitating addicts is still comparatively new.

The ILO team does not delude itself about job discrimination against addicts.

"Addicts are a very difficult problem indeed," Mr. N. E. Cooper, chief of the unit, told **The Journal**.

"They are not as predictable as other handicapped people. Many drug dependent people are regarded as outcasts by their families . . . this antipathy is often the toughest aspect of the whole problem.

"We are studying various models of resettlement and after-care services in developing countries, including in-hospital, half-way houses and sheltered workshops." he said.

The first major project, seen by organizers as a model for other countries, is in Thailand where ILO, the UN Narcotics Division, World Health Organization and the Food and Agricultural Organization, are working together on crop substitution, treatment, and vocational rehabilitation programs.

In Ethiopia, the unit helped to establish an umbrella factory where 400 "disabled" workers are now producing enough for the entire country, making a profit, and diversifying into transistor radio batteries.

In Viet Nam, one sheltered workshop is involved in mushroom cultivation.

In Thanyarak Hospital, near Bangkok, about 3,000 people, mostly heroin users, are being assisted and local staff are being trained in vocational aspects of care and after-care.

"We favor small workshops, cooperatives, home and self-employment for the disabled. Employment opportunities for these people in the usual industries in developing countries are limited.

Around the world

CANNABIS-CARRYING YACHTS
"Pleasure ships" as well as planes are being used by cannabis smugglers, France reported to the United Nations Narcotics Commission. A government spokesman said while traditional routes from Morocco and the Near East remained important, new sources—including Ghad, Guana and South America—had appeared.

RUSSIANS UNCONCERNED
Except for isolated cases of stealing morphine and codeine from pharmacies and abuse of "wild" cannabis, the problem of illicit drug abuse does not exist in the Soviet Union, Professor Edward Babaian, psychiatrist and president of the USSR Commission on Narcotic Drugs, told a United Nations meeting.

"UP IN THE AIR" CAMERAS
Mexican narcotics control officers are using aeriel cameras equipped with special filters designed to detect illicit cultivation of opium and marijuana. The move is part of a campaign designed to destroy crops in the country's northwestern region.

TOURIST WARNING
Jamaica has warned "young people and tourists" against smuggling drugs into its country where a law provides for severe prison terms. A government spokesman told a United Nations meeting that cannabis traffic in Jamaica is "mostly in the hands of such people."

BIG REPUTATION
Hong Kong's long-standing reputation as a narcotics center continues to thrive with the news that between 35-50 tons of opium have been imported annually from countries of the "Golden Triangle" in recent years. Last year, authorities seized large quantities of opium and morphine base, discovered seven clandestine laboratories and arrested 20 major operators and financers of criminal drug traffic.

SPANISH LURE
Young people from Latin America have started importing cocaine to Spain, a United Nations meeting was told. Spain, as a source of migrant labor as well as a tourist attraction, has become a transit country for illicit drug traffic.

Israeli police keeping active

TEL AVIV—Use of both hashish and opium is evidently on the rise again in Israel, although police claim recent figures reflect more "increased police activity" than anything else.

The year 1972 saw a low point in the number of police files opened (only 840); in 1973 the figure increased to 920. The just-published figures for 1974 show the number of files is 1,306.

The number of individuals charged also shows an increase from 1,275 in 1972 to 1,385 in 1973 to 1,928 in 1974.

Of these 1,928, the majority were Jews (1,373); while Moslems (Israelis) came second with 363. Tourists (of all nationalities) accounted for 167 and Christian (Israelis) for only 25.

The quantity of hashish impounded rose from 96 kilograms in 1973 to 671 kg in 1974; opium fell from 45 kilograms to 20 kilograms.

The number of drunken drivers increased by more than threefold. Of the 680,725 police summons issued for all offences, 20 were for drunken driving; in 1973, there were only six such offences.

U.N. shocked by British complacency

By ALAN MASSAM

LONDON: The complacency with which some British health officials approach narcotics has been badly shaken by a group of visiting experts. The occasion was a travelling seminar on drug abuse which visited Dutch and Swedish centres before getting to Britain. Backed and therefore having the authority of the United Nations, the seminar toured several London drug treatment clinics.

A summary of the 14-strong seminar's findings was given to **The Journal** by Bob Searchfield, co-ordinator of the British Standing Conference on Drug Abuse.

He said: "Most of the overseas experts were shocked to find that British drug treatment centres are suffering from a chronic shortage of funding. Several individuals were strongly critical of the British approach to the problems. It was a disappointment to them too because British ideas are often thought to be enlightened.

"One of the most telling observations, in my view, was that the British system of prescribing hard drugs through Government clinics had turned some drug users into sick people. It had contained the spread of drug abuse, but at the same time it had made individual drug users dependent on the clinics.

Mr. Searchfield said that the visiting experts had been particularly appalled by the atmosphere at a community drug project in Camberwell, South London. "They found a very depressing situation in which young people had been maintained on drugs for quite a long time and for whom there seemed very little hope."

He went on: "In Britain the drug user is getting drugs, but the question that many of the seminar participants asked was—how do you solve the problem of drug addiction with more drugs? I would say that you do not although maintenance plays a part in helping the addict. What we really need is more resources to be made available to community-based social agencies. These could help the drug user rehabilitate into society."

Delinquency rate peaks but drug use increasing

By JOSEPH GRIMM

DESPITE WIDESPREAD fears and even official statistics to the contrary, juvenile delinquency in the United States may have reached a peak. The one area of exception is drug abuse.

A recently released study shows no significant increase in juvenile crime rate in the U.S. between 1967 and 1972.

Drug use, however, was nine times greater in 1972 than in 1967 although the report suggests two possible reasons for this increase . . . self-reported incidents of drug use were very low in 1967 and a large proportion of reported incidents involved marijuana.

The study was based on self-reported delinquency by a representative national sample of 13- to 16-year-olds. It was performed by Drs. Martin Gold and David J. Reimer of the University of Michigan.

The report says "the rise in drug use and concommitant decline in some other offences among boys suggests that from 1967 to 1972 the use of drugs became more satisfying to the deviant adolescent appetite than the other offences were.

"The horror that marijuana use had been, had come to seem more tame, not unlike other kinds of delinquent behavior. It no longer required such extreme alienation from parents before it was, in a sense permitted.

"In short, science and experience had eroded the marijuana stereotype. We believe that this had occurred among American adults and most important here, among American parents. If it had not, we doubt that adolescents would have taken up drug use to the degree they had in 1972."

Teens' perceptions of drug use among their peers also changed from 1967 to 1972. Asked how many of their peers they thought used illegal drugs, responses from the two surveys show that among boys and girls, drug use came to be perceived as a more normal adolescent activity.

In 1967, both users and non-users saw themselves as outsiders. Drug users thought their peers didn't use drugs and non-users thought their peers did. By 1972 socially active users believed their drug use was typical of teens in general.

Other contributing factors to the increase in illicit drug use could be an increase in the teens' perceived autonomy and increased social activity. Gold and Reimer note a significant increase in the amount of parental autonomy that boys reported from 1967 to 1972.

Social change: "Think of the children"

June Christmas

CONCERNS ABOUT services and the place of women in society are only a part of a larger issue, according to New York City's commissioner of mental health and mental retardation.

That larger issue is "our concern about human life and the quality of human life", the commissioner told the conference.

"Unless we can match our talented competence in the field of drug addiction with an equal commitment to social change, right where we are, and social issues must be part of our concern, we will continue to have that woman who suffers, the family, the child.

"Think of the children", said Dr. June Jackson Christmas.

She called for a wider variety of treatment approaches directed to the specific needs of specific groups.

"Lack of attention to individual and group characteristics and lack of adequate development of a variety of approaches . . . is typical of a public policy that emphasizes symptomatic treatment while minimizing the effects of the social context, and pays little attention to prevention and none to ameliorating the conditions that make addicts."

What women are finding out now, black, brown, yellow and red people have known for some time, she said. If they are in any position of authority, "maybe they're there to add a little local color or to put down a local uprising".

To individualize approaches to specific groups, "we must know something about the group. Far too often, how we individualize women is based upon what we know about men".

Staff awareness and education is essential. "We must develop a deeper knowledge of the part of staff."

The successful middle-aged black woman does not need a white establishment person to tell her she has emasculated her male. She does need to determine if her compulsive drinking is related to her efforts to control her own assertiveness lest she be called an aggressive female, said Dr. Christmas:

The white working class teenager, caught in drug experimentation and at the same time struggling for independence from her divorced mother, may be more responsive to the peer counselling group in her own high school than to a casework relationship in a drug education program which labels her prematurely and reinforces her feelings of guilt, she said.

For the young woman whose heavy drinking accompanies her conflict over acceptance of her lesbianism, gay counselling groups can focus on her as a whole person whose alcoholism and sexuality are but a part of her being.

"Further, we must eliminate that sexism in employment that means that most of our agencies are headed by men and men at many levels are represented disproportionately in positions of power."

In addition to a variety of services geared to specific needs, a variety of helpers is also needed, she said.

"To move from the extreme of non-understanding and rejecting physicians who used to discount addicts and alcoholics and not want to care for them at all, to relying solely on a staff recruited from the ranks of ex-alcoholics or ex-addicts might be to repeat the earlier problem . . . of rigidity.

Essential is flexibility in staff patterns—use of professionals and para-professionals along with components of self-help—and awareness of what knowledge can stem from experience as well as what training needs to be added to experience.

Rehabilitative justice offers hope

AT EVERY significant point in the criminal justice system, there can and should be a rehabilitative alternative to the traditional operation which for many drug abusers leads to incarceration.

"The development of these alternatives within the criminal justice system is a primary goal of the interdisciplinary approach, Donald E. Jones told the conference.

This approach brings together the circle of rehabilitation and the circle of criminal justice and "offers new hope, possibility and credibility for our communities which are dealing with people problems".

It is based, he said, on the principle of rehabilitative justice—"justice under the law that rehabilitates a person back into society in such a way that the person and the society are satisfied with the process and the end result; and rehabilitation that not only changes the individual and provides him with new skills for living, but also changes the systems in the community to be more responsible and just to the needs of the people—minority and majority—who live in that community".

Through this approach, "communities can be viable places to live and work".

This is neither an "idealistic theory or a dream", said Mr. Jones, regional coordinator in Pensacola, Florida, for the Bureau of Drug Abuse Prevention, division of mental health, state department of health and rehabilitative services.

It is "a reality that has been happening (in Florida) . . . for more than a year now and has done much to bring the community together".

"The development of the principle of rehabilitative justice and the use of the interdisciplinary approach in coping with the drug problem is a viable and working model for other countries and communities to consider."

Clients of the two disciplines of criminal justice and rehabilitation must receive rehabilitation as well as justice. Professionals of these systems must think in "both—and" terms rather than "either—or" terms, he said.

"Just as the criminal justice system needs to make distinctions between the pusher, addict, abuser-user and experimenter, so does the rehabilitation technician need to make distinctions between punishment-correction, prosecution, law and order, and justice."

They should recognize the justice system is more than punishment and prison, and that law and order can be interpreted in many other ways than it was in the late 1960s.

"The rehabilitation technician might be a PhD psychologist or a former drug addict. But, regardless of training or experience, the technician needs to be a 'hooker' of the highest quality—not only of clients into the therapeutic process but of other community systems into the therapeutic process."

People in rehabilitation should see the justice system can be an alternative, not the "fall guy or a scare tactic alternative, but a realistic alternative which can result from violation of community laws".

"Drug programs would find their work much more successful if they had a full time criminal justice liaison person on the staff, working in jails, courts, and correction centres, and assisting the criminal justice staff in coping."

A CALL FOR PAPERS

A RENEWED emphasis on scientific content, and an extension of interest to tobacco and alcohol as drugs of abuse, is to highlight the 1976 National Drug Abuse Conference, to be held in New York City March 25 to 29.

Dr. Joyce H. Lowinson, chairperson for the forthcoming conference, told **The Journal** that efforts are now being mounted to stimulate submission of abstracts and papers for that conference.

SEE EDITORIAL PAGE 8

"We want to make this a much more cohesive effort, we want to emphasize that this will be a structured program in which the speakers and panel participants will have the time to adequately prepare their materials," said Dr. Lowinson.

"There are a lot of people in this field who have a lot of valuable things to say, but don't necessarily have much experience in preparing scientific abstracts and papers. We want to help them in this respect."

Dr. Lowinson noted that a call for papers would be issued soon, but that in the meantime any individuals in drug and alcohol programs who have ideas worthy of presentation but who don't have the resources to put them into acceptable form are asked to contact Dr. Lowinson . . . National Drug Abuse Conference, 1500 Waters Place, Bronx, N.Y. 10461.

ANNE MACLENNAN

reports from the

National Drug

Abuse Conference,

New Orleans, La.

Complications unfold

Motherhood for addicts

THE REALITIES of motherhood may come as a cruel shock to addicts, according to a Philadelphia team.

Many addicts visualize the birth of their babies as the source of immediate positive change in their lives, Ms. Tovia Freedman of the Family Centre Program at Philadelphia General Hospital, told the conference.

"The reality that a newborn requires care 24 hours a day is very abstract until the baby is born. With a set of expectations that cannot be fulfilled, the path for continued dysfunction is created."

The women, she said, look to their babies for love. What they get is dependence which is seen by them as being demanding and as a way of displeasing the mother. Crying is interpreted as the baby's rejection of the mother.

The baby's powerlessness becomes, in the mother's mind, her own powerlessness, said Ms. Freedman.

The Family Centre Program, which has studied drug-dependent mothers and newborns for four years, provides comprehensive medical care, methadone maintenance, vocational rehabilitation and therapeutic interventions, specifically family therapy.

Having based their early work on the illness approach, the centre team initiated a family oriented modality which places the major responsibility for the addiction on the environment.

"It is the contention that within the structural frame of reference, work begins with family systems and within these family systems change can be created that will enable the family members to use their own resources or develop alternatives so they can function in a more constructive way."

Many addicts, she said, become "stuck" in the developmental process at the stage where daughter should become wife, mother, young adult. Separation from the parent figure has not happened and the addict is caught in conflict between remaining daughter and becoming wife/mother.

"The use of drug addiction for a woman as a solution to her role conflict is an area we are just beginning to explore," she said.

However, "we can hypothesize that the use of drugs may resolve the need for a woman to solve her conflicts. The drug becomes a protection against having to choose a new role. Pregnancy and birth reawaken the need to resolve this role conflict.

"If she is at the stage of development that requires her to be dependent on her mother, how can she herself become a mother?"

Although it is not possible to isolate generational dysfunction as the only difficulty drug-dependent women have, the problem "is a striking one that needs to be seen in combination with a multitude of other problems", Ms. Freedman said.

"Addiction needs to be explored within our society or environmental structure. The structural approach becomes the framework for the family system approach and although our direct intervention is with the family, our long range philosophy and work involves changes in the environment."

Pregnant and drugged

BARBITURATES: SALICYLATES or quinine have been found in 22% of urine samples from pregnant women admitted at term to Mount Sinai Hospital, New York.

The findings are significant and "may reflect the widespread availability of drugs in our society and a widespread attitude amongst patients that drugs are safe," Dr. John E. Jacoby, department of pediatrics and obstetrics, told the conference.

Dr. Jacoby said most drug abuse literature has been retrospective, describing symptoms in babies of mothers known to be using drugs.

His research was aimed at studying the "actual extent of drug abuse in a pregnant population and determining if there was a significant amount of clinically inapparent drug abuse."

The urine samples were collected from women admitted over a two month period, during which time there were 479 deliveries. For various reasons, among which were failure of the patient to urinate prior to delivery and urine mixed with blood, amniotic fluid, or stool, 92 samples were collected. Of these, 86, or 17.9% of the deliveries, remained the sample.

Dr. Jacoby said there was no apparent bias in the sample group.

"The characteristics of the cohort of patients whose urines were analyzed seem to agree with the characteristics of the population of mothers giving birth," he said.

Nineteen of the 86 samples, or 22%, showed barbiturates, salicylates or quinine. No other drugs were detected.

Although quinine is used to cut heroin, it may also be present in tonic drinks, Dr. Jacoby noted.

Several methadone patients gave birth during the study. However, failure to detect methadone is based on sample size, Dr. Jacoby suggested.

New Books

By RON HALL

Sociological Aspects of Drug Dependence

. . . edited by Charles Winick
CRC Press, Inc. (18901 Cranwood Parkway, Cleveland, Ohio. 44128), 1974.
references: index: 337p.: $39.95

Part of series, 24 contributors deal with theory, education and mass communication, prevalence, treatment and resocialization, and social costs of drug dependence. The studies range from a report of the use of psychotropic drugs in American families to a program to combat the drug-crime syndrome.

Chemical Coping: a report on legal drug use in the United States

. . . by Carl D. Chambers, James A. Inciardi, and Harvey A. Siegal
Halsted Press (605 Third Avenue, New York, New York. 10016), 1975.
index: 163p.: $10.95

Based on interviews with 30.000 people in the U.S., the extent of use and the characteristics of those most involved with prescription drugs, over-the-counter non-prescription drugs and alcohol are presented. A brief history, drug effects and drug interactions accompany the statistical material.

Medical Aspects of Drug Abuse

. . . edited by Ralph W. Richter
Harper & Row, Publishers, Inc. (2350 Virginia Avenue, Hagerstown, Maryland. 21740), 1975.
illustrations: references: index: 418p.: $22.50

In a well-illustrated book designed for health professionals, 54 contributors deal with various medical aspects of drug abuse including pharmacology and behavioral effects, and a review of the management of medical complications.

Reaching Out: Helping Young People in Trouble

. . . by Brendan John Sexton and Patricia Cayo Sexton
Agathon Press (150 Fifth Avenue, New York, New York 10011), 1975.
256p.: $8.95

In a book drawn from personal experience, the principal author discusses the needs and feelings of young people; various approaches to therapy; adolescent relationships and their interaction with parents, teachers, police and other adults; the effects of addiction on society; and the specifics of starting and running a drug program.

Other Books Received:

Police Chiefs Discuss Drug Abuse: Pomeroy, Wesley A., Drug Abuse Council, Inc., Washington, 1974, 77p.

Drug Addiction: Singh, Jasbir M., and Lal, Harbans (eds.) Stratton Intercontinental Medical Book Corporation, New York, 1974, 286p., $20.75.

Marijuana: Medical Papers 1839-1972: Mikuriva, Tod H. (ed.) Medi-Comp Press, Oakland, 1973, 465p., $8.45.

'Recognition dinner'

BETWEEN 500 and 600 people are expected to honor the retiring director of the Center of Alcohol Studies, Rutgers University, at a special "recognition dinner."

The dinner for Seldon D. Bacon will be held July 16 at Rutgers, the State University of New Jersey. It is being planned in association with the Alumni Institute, July 13-17.

Although he is retiring, at age 65, as director of the Center, Dr. Bacon will continue at the university as professor of sociology.

Chairman of the dinner will be R. Brinkley Smithers. Heading the list of several speakers at the event will be Dr. Morris Chafetz, Director of the National Institute on Alcohol and Alcoholism.

Dr. Bacon's past positions and afiliations are many. They include:—

Chairman of the Board, Connecticut Commission on Alcoholism, 1945-60; secretary-treasurer, National Council on Alcoholism, 1945-50; American Medical Association Commission on Alcoholism, 1956-63; National Safety Council, Committee on Alcohol and Drugs, 1960—; National Advisory Committee to HEW Secretary on Alcoholism, 1966-68; International Council on Addictions, executive committee, 1968—.

Seldon Bacon

Tickets for the dinner, at $25 each, are available from Mrs. Geraldine Howell, Rutgers Centre of Alcohol Studies, Smithers Hall, The State University, New Brunswick, N.J. 08903.

Anesthetized dogs tested to learn cause of nausea

By LACHLAN MacQUARRIE

BANGKOK—The nausea and vomiting that follow alcoholic drinking may be the result of increased electrical activity in the gastro-intestinal tract, according to three Thai physiologists.

They point out that this effect is generally thought to be the result of either local irritation on the stomach or of a direct effect of alcohol on the central nervous system.

They base their suggestion on the results of a study of the effects of alcohol on the electrical activity of the gastro-intestinal tract of anesthetized dogs.

The three, Drs. Piraj Wongta, Chucheep Prapootpitaya, and Montri Kantapura of the department of physiology, Chiang Mai University, Thailand, reported their work here at the 31st International Congress on Alcoholism and Drug Dependence.

Ten mongrel dogs weighing between 10 and 15 kilograms were anesthetized with 20 mg per kg of body weight of nembutal. All of them had been deprived of food for 18 hours. The abdomen of each was opened by a mid-line incision and electrodes were sewn to various parts of the stomach and intestine.

When the electrical activity was steady in each case, 500 ml of 20% ethyl alcohol was given to the dogs through a stomach tube at the rate of 50 ml per minute. Every 15 minutes, 5 ml of blood was withdrawn from the vein and the blood concentration of alcohol measured.

One dog was given the same amount of alcohol intravenously; and the control experiment was done by recording the electrical activity in another anesthetized dog given 500 ml of tap water through the stomach tube.

The average values of both the amplitude and the frequency of electrical activity was calculated in each case.

It was found that with the blood level of alcohol between 0.4 and 0.22 mg per cent there was little change either in amplitude or frequency of electrical activity.

But when the alcohol blood level reached 0.27 mg per cent, both amplitude and frequency began to increase significantly. This increase took place in the duodenum and the jejunum as well as in the stomach, and reached the highest point when blood alcohol level was between 0.3 and 0.4 mg per cent.

The dog receiving the tap water showed no change in electrical activity. The dog given alcohol intravenously showed the same increase in stomach electrical activity as the dogs fitted with the stomach tubes.

The authors conclude that, "because the electrical activity causes the contraction of the gastro-intestinal tract, the nausea and vomiting experienced by the drinker may be the result of the increase in both amplitude and frequency of electrical activity in the stomach, duodenum and jejunum".

'Brotherly love' hard to find outside TC's

By MILAN KORCOK

TORONTO—Making the transition from the "clean, pure environment" of a therapeutic community back to life on the street can be a traumatic experience for the ex-drug user.

After months or even years in a community of peer support and "brotherly love", the user needs all the help he can get in taking that step back to a hard, brutal world, Charles Devlin, administrator of New York's Daytop Village, told a one-day seminar at the Addiction Research Foundation of Ontario.

In many respects, the total honesty, the confrontation, the almost "religious" quality that is an essential component of programs such as Daytop, is like "Alice in Wonderland", said Devlin.

In facilitating this transition back to the street, professional workers such as psychiatrists, social workers, and psychologists are proving increasingly useful, he said.

When an addict first comes into the program, what he requires most is a peer relationship. He needs love and understanding. He doesn't want to have to talk "up" to anyone.

In this respect, in a day-to-day peer working relationship with an addict, "most of these professionals are quite ineffective," said Devlin.

Professionals do begin to come into their own when problems arise that are beyond the scope of competence of the ex-addict peer.

More and more, people are centering the Daytop program with deeply-rooted problems that extend beyond their drug use, said Devlin.

"We just tell our staff to identify these problems, not to try to handle them on their own. If we can get a psychiatrist to work with the addict at this stage, that is where he really works well," said Devlin.

In response to questions from his audience of community workers, Devlin said use of ex-addicts in treatment programs—particularly at Daytop—has been declining.

"And that's the way I want it. Just because somebody was an ex-addict we thought he was qualified. That is ridiculous. Many of these non-qualified people were doing more harm than good.

"We are now getting a more qualified kind of person," he said.

Efforts are now being made to send ex-addicts after treatment to non-drug related jobs before accepting them back as workers.

Once in these jobs, most ex-addicts do not want to come back, he said.

"They go out, they like it, they get used to it, and this is great."

He noted that Daytop now has more than 1,000 graduates—addicts who have completed the full program cycle.

But of the thousands who have started but failed to complete the full course, there is a surprisingly high number of successes, said Devlin.

Recent Daytop research indicates the re-entry success rate of non-graduates who spent at least one year in the program is about the same as among graduates.

Of those sampled "80% are doing marvellously" said Devlin.

Outlining the continued need for programs such as Daytop, Devlin had harsh words for both municipal and federal authorities.

The corrections system does not cooperate very enthusiastically, said Devlin.

"The system doesn't want involvement with us. They are just interested in confining individuals. They just like to make the prisoner learn to respond."

As for the federal government and its involvement with methadone maintenance: "They really blew it with their methadone programs. I believe they copped out totally. They got conned into thinking that methadone was the answer.

"Private clinics were opening up all over New York. People were making millions of dollars off the addict," Devlin claimed.

"That attitude has changed. If a person needs treatment he ought to be given options. Because if he's killing himself out there with dirty needles, and he knows he can't face life drug free, any treatment is better than what he is going through on the street."

"Drug free" is still the answer in addict therapy, said Devlin although he admitted to a softening of attitudes in respect to methadone over the years.

"In the past, if a person didn't want to be drug free we didn't believe in giving him anything."

'The big lie'

Controlled drinking

MILWAUKEE—A sharp attack on researchers who rush to publish without any evidence of long-term studies of altered drinking patterns in recovered alcoholics has come from Dr. David Pittman, Ph.D., Washington University, St. Louis.

He said that control drinking is as much a misnomer as the "stabilized heroin addicts" he failed to find in research in Britain in the late 1960s.

Dr. Pittman, who was attending the annual forum of the National Council on Alcoholism here, said British Dr. D. L. Davies work, Normal Drinking in Non-Recovered Alcoholics, "is an absurdity in itself because to me a normal drinker is a person who can take alcohol or leave it and who really has no concern whether there is alcohol at a party or not."

Most of Davies' patients drank only beer and an occasional glass of wine and no spirits. "That is far from being normal social drinking."

Dr. Pittman, director of the Social Science Institute at the university, said the term is as misleading as the heroin "stabilized addicts" he and Dr. Max Glatt searched for. "Unfortunately we never found them," as their book revealed.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

One-Day Course on Desensitization Training for Drug Abuse Addicts - June 3, New Hyde Park, N.Y. Information: Office of the Dean of the Clinical Campus, Long Island Jewish-Hillside Medical Center, New Hyde Park, N.Y. 11040.

10th Annual Conference of the Association of Halfway House Alcoholism Programs of North America, Incorporated—June 8-11, Hot Springs, Arkansas. Information: Jack Shea, Conference Coordinator, Association Office. 786 E. Seventh St., St. Paul, Minnesota 55106.

New England School of Alcohol Studies—June 8-13, University of Vermont, Burlington, VT. Information: Jan S. Durand, Coordinator, P.O. Box 11009, Newington, CT 06111.

21st International Institute on the Prevention and Treatment of Alcoholism—June 9-15, Helsinki, Finland. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Alcohol, Drug Abuse and Mental Health 1975—June 12-15, Oakland, Calif. Information: Alcohol, Drug Abuse and Mental Health 1975, P.O. Box 9945, Mills College Station, Oakland, Calif. 94613.

American Medical Association Meeting - June 14-19, Atlantic City, N.J. Information: Dr. J. H. Sammons, Executive Vice-President, 535 N. Dearborn Street, Chicago, Illinois 60610.

98th Annual Convention of Ontario Woman's Christian Temperance Union—June 17-19, Guelph, Ont. Information: Ontario Woman's Christian Temperance Union, 485 Waterloo Ave., Guelph, Ont.

21st Annual June Assembly of the North Conway Institute—June 18-20, New Hampshire, Mass. Information: North Conway Institute, 8 Newbury St., Boston, Mass. 02116.

Eighth Annual Eagleville Conference on Alcoholism and Drug Addiction—June 20, Eagleville, Pa. Information: Patricia Moretti, Conference Registrar, Eagleville, Pa. 19408.

Joint Meeting of the Canadian Medical Association and the Alberta Medical Association—June 22-27, Calgary, Alberta. Information: Ms. H. Otto, CMA, Box 8650, Ottawa, Ont. K1G 0G8.

Rutgers Summer School of Alcohol Studies—June 22-July 11, New Brunswick, N.J. Application deadline May 1. Information: Miss L. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

Summer Alcohol and Alcohol Education Institute—June 23-July 11, State University College at Brockport. Information: Dr. John S. Sinacore, Professor of Health Science, State University of New York, College at Brockport, N.Y. 14420.

First Annual Deep South School of Alcohol Studies - July 6-11, Shreveport, Louisiana. Information: Sam D. Thomas, Director, Deep South School of Alcohol Studies, Centenary College, P.O. Box 4188, Shreveport, Louisiana 71104.

Triennial Refresher Course for Alumni of Rutgers Summer School of Alcohol Studies - July 13-17, New Brunswick, N.J. Information: Miss L. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

Sixth International Congress of Pharmacology—July 20-25, Helsinki, Finland. Information: Secretariat, Sixth International Congress of Pharmacology, Siltavuorenpenger 10, SF-00170 Helsinki 17, Finland.

Eighth National Conference on Alcohol and Drug Education—July 21-25, Ponteland, England. Information: Secretary, TACADE, 437 Royal Exchange, Manchester M2 7EP, England.

Behavioral Approaches to Alcoholism and Drug Dependencies—July 31-Aug. 1, Seattle, Washington. Information: Office of Short Courses and Conferences, DW-50, University of Washington, Seattle, Washington 98195.

Seventh Annual Summer School on Alcohol and Other Drugs—August 4-15, Berkeley, Calif. Information: Herman J. Kregel, Director, Berkeley Center for Alcohol Studies, Pacific School of Religion, 1798 Scenic Ave., Berkeley, Calif. 94709.

Institute on Addiction Studies - August 17-22, McMaster University, Hamilton, Ont. Sponsored by Alcohol and Drug Concerns, Inc. Information: David Reeve, 15 Gervais Drive, Don Mills, Ont.

Fifth International Conference of the International Association for Accident and Traffic Medicine and the Third International Conference on Drug Abuse of the International Council on Alcohol and Addictions—Sept. 1-5, London, England. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

CHAPTER ONE

THE NARCONON STORY

TORONTO—In a "flag bureux (correct) data letter" in 1972, founder of Scientology L. Ron Hubbard declared, "Narconon is the ONLY successful drug rehabilitation program on the planet."

He's hardly an objective observer, since he wrote the programs that Narconon uses.

But when Narconon officially opened its Toronto headquarters last week in a $140,000 house, its mortgage was guaranteed by Central Mortgage and Housing Corporation and the down payment came from a federal government grant.

With a preamble of six laudatory whereas'es, the Governor of Louisiana last fall proclaimed Narconon Week and urged everyone in the state to become aware of the programs it offered.

Last summer in California, the legislature passed a resolution commending and congratulating Narconon for its "successful and effective salvaging of persons who have become involved in criminal or drug/alcohol abuse."

Most of a half-inch thick booklet called "Narconon Fights Drugs . . . and Wins" is devoted to testimonials, case histories, newspaper stories and letters from an assortment of officials that generally hail it as the greatest thing to come down the rehabilitation turnpike since artificial legs.

It is now operating in 13 countries, and in four Canadian cities—Vancouver, Calgary, Toronto and Ottawa. It was federally incorporated in December, 1972, and is a non-profit, charitable organization under federal registration number 0415-216-57-13. Donations are recognized as charitable for income tax purposes.

The enthusiasm is not universal. There is no doubt that in the minds of some, Narconon's image is fused with adverse publicity that has surrounded Scientology.

More are critical of its claims to have an 80-90% success rate for drug abuse—figures several observers say cannot be scientifically substantiated.

So what is this program that claims it has found the actual causes of "the fatal trends of criminality, alcoholism and drug abuse" and is actively resolving them?

Narconon stands for non-narcosis, and narcosis is defined as "stupor or insensibility"—not necessarily from chemicals.

"Narconon is basically a problem solver", says Joe Keldani, national director of the program in Canada. "Drugs are a side thing that we have to work through to get to where we're going. There's drugs, there's alcohol, there's crime, there's simply narcosis, any form of it. Narcosis is what stops a person from being able to handle his life."

Narconon holds that the cause of chemical abuse and anti-social behavior is a basic inability to achieve a satisfying self-image and to form satisfying relationships. Ergo, develop the abilities and attitudes the person lacks, and he no longer needs, or takes, these ways out. He achieves "self-determinism" and gains control over what happens to him.

The program started in the Arizona State Penitentiary in 1966 when inmate William Benitez, a long-term drug addict, read one of L. Ron Hubbard's Scientology booklets.

Narconon literature describes Hubbard as "the American philosopher and scientist". He is commonly known as a former science fiction writer.

After publishing his theory of dianetics in Astounding Science Fiction in 1950, he expanded it into a best seller, Dianetics: The Modern Science of Mental Health. Following the book's popularity Hubbard formed the Church of Scientology in the mid-50s.

With Hubbard's books as a base, Benitez organized a group of addict inmates. From their success in straightening out their lives, the program spread, originally to other penal institutions, then more generally. It has been endorsed by many prison officials, and in Canada operates at two B.C. institutions.

Those with reservations about Narconon tend to choose their words carefully.

It is not unusual for Scientology's history of launching lawsuits against critical authors, or libraries and stores that carry their books, to be mentioned. "If you say anything negative, they sue you," was one comment, by a doctor who did not differentiate between Scientology and Narconon.

"I think there's a fear of their incredible budget for suing," said another, referring specifically to Scientology.

One of the most consistent criticisms, however, is Narconon's success claims.

Dr. Wilf Boothroyd, a psychiatrist and senior medical consultant to the Addiction Research Foundation of Ontario, says, "They claim an 85% success rate. I've never seen that documented in any convincing way and I would doubt it is that high."

Similar views come from Dr. Lionel Solursh, associate professor of psychiatry at the University of Toronto, and chairman of the Canadian Medical Association's sub-committee on the non-medical use of drugs.

"I don't know of any reasonable assessment of either their procedures or their outcome, made by themselves or any scientifically-oriented individual, so I don't think that any of us in the drug dependence or mental health fields can, with any confidence, make an accurate statement about the methodology, indications, contra-indications, degrees of success by various measures, and so on."

THE BACK PAGE

Both men consider a two-year follow-up a reasonable period for assessing the success of any rehabilitation program.

Narconon's original success claims came from recidivism rates among prisoners who had been in the program, compared to those who hadn't. Its more recent literature, however, does not restrict those claims to prisoners.

"In the United States, where the programs have been operated for a sufficient period of time and on sufficient numbers of participants to tabulate meaningful results, an overall success rate of 85% has been arrived at (ranging from a low of 70% to a high of 97.5%).

"In Canada, Narconon programs have not been operating long enough on sufficient numbers of people for the success figures to be reliable yet."

Mr. Keldani demures from giving a rate for non-prison programs, pointing out the difficulty of follow-up with a mobile population. "We just claim it's pretty damn good."

The cost of the program to the person taking it is also raised when those outside Narconon, but active in the drug scene, are questioned. Again, they are really unclear how much applies specifically to Narconon, and how much to publicity that has surrounded those who have joined the Scientology movement.

Dr. Boothroyd had heard "concerns expressed many times by many people" about the cost of Narconon courses, and to anyone making enquiries about the program, "I would say that I don't know what it might cost, and that would have to be explored and considered, along with other things in the program."

Mr. Keldani says that although Narconon has a rate schedule for its various courses, "Druggies don't have money", and it gets no more than a "couple of hundred a year" total from students on the courses.

Rather, Narconon places more emphasis on getting donations from the community to support the program, and more often works out arrangements with students where they contribute something . . . chores or helping in the program in exchange for their fees.

There is also a curious dichotomy between the emphasis in Narconon literature about self-determinism and being in better control of your environment, and the impressions that some outsiders have of the program.

Marilyn Meshberg of North York, a borough of Metropolitan Toronto, has never been involved in crime or drug abuse, but she has some first-hand impressions of Narconon techniques.

In 1972 she was a parent volunteer on a North York Board of Education committee that assessed the Narconon approach for its suitability as part of a drug education program in the schools. The nine-person committee did not recommend it.

"They (Narconon Staff) came in for two days and laid out the whole thing, the dictionary for the mumbo-jumbo, the E meter with the tin cans . . . I felt I was being programmed into a robot, and I'm trying to become an aware person. This was talking 10 steps backward . . . I've heard the drug program has worked for some kids on drugs. But it seems to be they're transferring their dependency on drugs to Scientology."

June Callwood, the Toronto writer who was founder of Yorkville Digger house, has similar views about dependency.

"Narconon doesn't change the dependency, it just transfers it from drugs to Narconon. In my mind, there is no change in a person's growth . . . they pull the program around them like a Linus blanket.

"I gather they don't push Scientology, but all the programs are Scientology personality programs. They sincerely have found Scientology has helped them, and they're pretty nice people. Damn it, that's the awful part of it. If there is any kind of charismatic feeling, and you pour it on someone who has wiped up the streets for years, it's bound to work.

"It isn't the content, I just think it isn't a good idea to do this to people, to give them a life-long addiction to Scientology." She feels the same way about methadone maintenance programs that trade one addiction for another.

The vagueness about the tie-in between Narconon and Scientology, and the idea that involvement in one leads to the other, is a recurring theme.

Mr. Keldani says there is no pressure for Narconon students to join the church. He doesn't attend its services, although he considers himself a Scientologist "in the sense that I believe in what they're doing. I believe in the technology. Very much so, or I wouldn't be using it here. It does work."

In the foyer of the Narconon headquarters in Toronto is a box for letters to Ron Hubbard, with a sign quoting his rule that letters adressed to him shall be opened by him.

By BETTY LOU LEE

Policy letters from the Narconon board of directors state that many social programs around the world are using the Hubbard research and discoveries, but are separate from the Churches of Scientology.

"Since the responsibility of maintaining the high level of technology belongs to the Church, approval to use that technology must be applied for and consultation maintained to insure that the social program in question does, in fact, train its staff to adequate levels of ability and provide the highest possible standard of service . . . So long as the social program uses standard technology, management consultation will be provided by the Church."

Dr. Boothroyd of ARF says he knows of four people who were helped by Narconon. "The last I heard, two were still involved with Scientology . . . they were converts to the Scientology point of view. The other two were not. They were helped and went on to their own way of life."

"I know there is an intimate relationship between the two (Narconon and Scientology) but I don't know what the organizational connection is. I know there is some but it's very difficult to find out exactly what it is."

He does not accept the theoretical base on which the Scientology movement is built. "The theoretical background is just not intellectually convincing. I'm distinguishing in my thinking between Narconon as a program and Scientology as an ideology.

Toronto headquarters

"On the other hand, in spite of my strong objections to Scientology as a way of thinking, application of the method of Scientology, the direct confrontation method that Narconon uses, is, in fact, successful for some patients. And you can't quarrel with success even though it's achieved by means that of an ideological basis I could not accept. But it does work for some patients, and that's the proof of the pudding."

If he were asked about Narconon by a psychiatrist who was thinking of referring a patient?

"I would say it does offer a service that is successful for some patients. If he was inquiring about sending a patient, I could think of three or four different places, of which Narconon would be one. I don't know enough about their program to be at all confident about recommending it for any particular type of patient."

Dr. Solursh doesn't reject Narconon's program either, despite his reservations about its claims.

"Narconon's undoubted liason with the Scientology Mental Health empire has reflected in the views that many people have of Narconon, and decreased its acceptability or acceptance level in the community at large. That's not a value judgment, it's just a straight comment.

"There's too great a tendency, to put down, or to laud, various organizations and I think that applies to Narconon as much as any other. We really lack a good data base. I feel reasonably sure that Narconon themselves lack a good data base or mode of assessing data. So we can't really make any good judgments unless they are tainted by factors that probably shouldn't be applicable."

He has referred one patient to Narconon, too recently to assess any outcome. "I get the impression—and this is purely impressionistic—that for people who are very dependent personalities and likely to be so for many years to come, and who are looking for a very authoritarian kind of structure on which to lean, Narconon may in fact offer something that most other agencies are not prepared to offer." He made his referral on that basis.

"I think everything works for some of the people some of the time, and nothing works for all of the people all of the time."

(How the Narconon program works . . . **THE JOURNAL**, July 1, 1975)

The Journal

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Major pot law changes ahead

OTTAWA—After four months of public hearings, the Senate Committee on Legal and Constitutional Affairs has recommended a number of significant changes to the federal government's cannabis bill, including an amendment to eliminate, in effect, the controversial "reverse onus" for people accused of cannabis possession for the purposes of trafficking.

As important, the Committee has recommended an automatic pardon be granted all persons found guilty of a first offence of simple cannabis possession and then given an absolute or conditional discharge in place of a formal conviction.

Stiffer maximum penalties for those convicted by way of indictment for trafficking cannabis or possessing it for the purposes of trafficking are recommended: 14 years less a day in jail instead of 10 years.

And the maximum penalty for importing or exporting cannabis would be modified slightly from 14 years in jail to 14 years minus a day.

By using the 14 years less a day maximum penalty, even people convicted of the most serious cannabis crimes would still be eligible for absolute or conditional discharges under appropriate circumstances—such as when the trafficking or importing is shown to be done by amateurs as opposed to hardened criminals or professionals for the money exclusively.

In another important amend-

More from Ottawa—page 2

ment, the Senate committee recommends elimination of the minimum three-year jail sentence for importing, to give judges more flexibility in sentencing and also to permit use of the discharge provisions. Under the bill proposed by the government, the three-year minimum sentence would be waived only when an individual could prove to the court that the importing was for personal use only.

The virtual elimination of the "reverse onus" principle for people charged with possession of cannabis for the purpose of trafficking would be accomplished this way:

Instead of forcing the accused who is found guilty first of possession to prove he or she was not intending to traffic the drug, but rather had the cannabis for personal use, the amendment would give the accused and the prosecutor equal chances to prove their own case.

That is, the accused would first be given a chance to argue there was no intent to traffic the drug and therefore the charge should be reduced to simple possession, with less severe penalties.

Then the prosecutor would be given a chance to "adduce evidence to establish that the accused was in possession of the controlled drug for the purpose of trafficking".

The change, which would have cannabis treated as all other con-

(See—Major—page 2)

NIAAA director steps down

WASHINGTON—Dr. Morris Chafetz, the first director of the US National Institute of Alcohol Abuse and Alcoholism (NIAAA), has resigned effective September 1, the fifth anniversary of his joining the government.

Dr. Chafetz said the reason for his departure is a promise to his wife that he would not stay in government for more than five years.

"I tried to leave in April of last year, after the second Report on Alcohol and Health had been completed." he said. But he indicated he was prevailed upon to stay.

"However, he said, "I did promise my wife I would leave at the end of the five-year period and I think promises like that have to be kept."

DEA chief fired . . . page 3

Despite Dr. Chafetz's explanation, rumors persist that his resignation is, at least in part, related to increasing pressure from his opponents.

Observers agree that Dr. Chafetz, an outspoken advocate of "responsible drinking", stood on many a bureaucratic toe during his five years in office.

In a June 9 letter to Health, Education and Welfare (HEW) Secretary Casper Weinberger, Dr. Chafetz said he was announcing his resignation now to allow a "careful search for my successor and to permit an orderly transfer of my responsibilities".

Concerning his successor, Dr. Chafetz said whoever it is, "I sure hope it's a strong person. I think there are all kinds of challenges facing us and I'd like nothing more than to see someone who can take over and go beyond what

Dr. Chafetz

I think has been a remarkable accomplishment of the NIAAA."

The Alcohol and Drug Problems Association of North America (ADPA), based in Washington, moved quickly to launch the search for an appropriate successor.

In a letter to its 3,000 members, ADPA President H. Leonard Boche encouraged individuals to pass along their opinions so ADPA

(See—Chafetz—page 2)

While many tighten laws

BC goes easier on alcohol

By PETER THOMPSON

VANCOUVER—The chairman of British Columbia's Alcohol and Drug Commission applauds the province's new liberalized liquor laws.

Commission chairman J. Peter Stein said the new laws would have little effect on the rate of alcoholism or problem drinking.

"I just don't believe that the laws, by increasing access to alcohol, will increase significantly the rate of alcoholism in the province," Mr. Stein said.

"The effect of the laws will be to make it easier for responsible drinkers to get alcohol."

Mr. Stein said the legislation might mean fewer car accidents as a result of impaired driving.

Mr. Stein's support of the new legislation stands in direct contrast to the positions of several other provincial agencies—most notably the Addiction Research Foundation of Ontario. ARF scientists have demonstrated a direct link between rising alcohol consumption and the rate of alcohol problems and believe further liberalization of liquor laws is a sure-fire way of increasing total consumption.

As in most if not all provinces, liquor in BC is sold through government stores most of which close early in the evening. Anyone wanting to buy beer in the evening is faced with driving either to one of the few government stores that are open, or more likely to one of the province's beer parlors. The beer parlors are huge and often located at great distances from each other and the people who use them.

Walking to a corner store for more beer would be less hazardous than driving to a beer parlor if the person has already been drinking, Mr. Stein said.

Mr. Stein said research done by Robin Room of the University of California at Palo Alto, concludes that easier access to alcohol does not have a significant relationship to an increase in alcoholism.

He said Dr Room's work also indicates increased prices have little effect on the problem drinker. "He just spends more of the money available to him on alcohol," Mr. Stein said.

Changes in BC's comparatively restrictive liquor laws were introduced shortly after the New Dem-

(See—Alcohol—page 2)

FADS GO EASTWARD

MUNICH—A recent report by Bavarian narcotics and addiction experts seems to prove a point observers of international societal behavior have been making for a long time.

Fads and fashions, as well as patterns of crime and addiction, seem to have a distinct eastward bent in the mid-20th century.

The majority originate in North America, then envelope Western and ultimately Eastern Europe.

This seems to be as true of tastes in clothing and music, as it is in drug and alcohol usage.

According to a Bavarian state government report issued in early June, drug usage among juveniles here decreased markedly last year while alcohol consumption went up sharply.

"The peak of interest in and curiosity about drugs among youths has been reached," the report said. "Instead, attention is now focused on alcohol, especially among the younger age groups."

Although the number of addicts under treatment in state and municipal hospitals is still on the rise, Bavarian authorities expect this to decrease this year and next, along with diminishing interest in drugs.

The report did stress, however, that drug-related fatalities as well as cases of serious addiction are on the increase.

Every fourth patient being treated in Bavarian psychiatric hospitals at present is a narcotics addicts.

Native children sniffing gasoline

By MANFRED JAGER

WINNIPEG—Getting high on gasoline fumes has become a major problem among native children in isolated northern Manitoba communities.

Blood samples taken from 50 Shamattawa children aged six to 16 years recently showed that all suffered from an enzyme-lowering form of lead poisoning.

Shamattawa is a small Indian village about 200 miles northeast of Thompson, accessible only by aircraft.

The situation there was described by one of the researchers, Dr Robert Fostakowsky, a paediatric resident at Winnipeg's Health Sciences Centre, as "probably typical of such communities throughout the north".

His opinion was backed up by Dr Harold Rich of the medical services branch in the federal department of health and welfare, in Thompson.

Dr Rich said gasoline sniffing among native children is "much more prevalent" than had been thought.

"Maybe it all isn't just happening now," he said. "Maybe we just weren't aware of it.

"Lately, we have become very aware. I can tell you that Shamattawa certainly isn't an isolated situation."

It is tetraethyl lead—the organic lead content in gasoline—that makes it particularly dangerous as an inhalant.

"Simply put," said Dr Fosta-

(See—Children—page 3)

Pot smoking pilots - Page 5

INSIDE . . .

Pot pardons will become a reality

By BRYNE CARRUTHERS

OTTAWA—The Senate Committee's proposal for an automatic pardon for all persons given absolute or conditional discharges for first offence, simple cannabis possession, would prevent hundreds, possibly thousands of young first-time offenders from having to live with a criminal record for the rest of their lives.

One of the startling things uncovered by the Senate Committee on Legal and Constitutional Affairs during four months of public hearings, according to Chairman Senator Carl Goldenberg, was that the special absolute or conditional discharges sometimes used in first-time cannabis offences still left the individuals with a criminal record.

This fact, previously published in the **The Journal**, was in spite of the government's supposed intention to lessen the criminal-record stigma associated with simple cannabis possession by promoting use of the discharges in the courts.

Under the law, a court can find a person guilty of a relatively minor charge such as first-offence cannabis possession and not convict the individual. In place of the conviction, the court can give an absolute discharge or a conditional discharge (with a sort of probationary period attached).

During 1974, some 5,500 absolute or conditional discharges were granted out of a total of 30,485 drug convictions. Most of the discharges were given to first-time cannabis possession offenders.

Senator Goldenberg said that under the current law and the government's proposed new cannabis law (before any amendments by the Senate), the accused granted such discharges must still apply for a pardon even when given an absolute or conditional discharge.

While technically those granted discharges do not have a record of conviction, they do have a criminal record of being found guilty. And a criminal record is a criminal record.

The Senate committee also learned that many Canadians given discharges—and most are young people—never do get around to applying for pardons, either because they are unaware they could apply or even have to apply, or because they do not want to face the hassle of the police investigation required before any pardon is granted.

(One advantage of the discharges is that a person becomes eligible to apply for a pardon much sooner than a person actually convicted of the same crime. Usually the waiting period is reduced to one year following granting of an absolute discharge or following satisfactory completion of the terms of a conditional discharge).

In view of this confusing state of affairs, the Senate committee proposed that in the case of an absolute discharge for a first offence of cannabis possession, a pardon be "deemed to have been granted" automatically under the Criminal Records Act, notwithstanding anything else the Criminal Records Act might say.

In the case of a conditional discharge, the pardon would be granted automatically once the probationary period was completed satisfactorily.

The proposed amendment would allow the federal government to revoke such automatic pardons if circumstances warranted it—a power routinely given the government for all pardons under the Criminal Records Act.

Senator Goldenberg said the proposal to change the cannabis bill would introduce an exception to the general law applicable in Canada under the Criminal Records Act for persons given discharges.

(The discharges are sometimes given in other cannabis crimes, even for trafficking and importing if the court feels the circumstances warrant it. They are also used in shoplifting and other relatively minor criminal cases.)

With this in mind, the Senate committee further recommends in its report to the Senate that the Government consider granting automatic pardons when discharges are granted for other crimes, on first offence.

Major law changes

(continued from page 1)

trolled and restricted drugs covered by the Food and Drugs Act, would give the court a chance to weigh evidence on both sides.

A large number of legal experts appearing before the Senate Committee has complained about the application of this reverse onus procedure, saying it violated the accepted principle of a person's being assumed innocent of a particular crime (in this instance possession for the purpose of trafficking) until actually proved guilty by the prosecution.

The final session of the Senate Committee considering the cannabis bill, ended the way it started, before the television cameras. The committee hearings on cannabis took their place in the history of Parliament as the first occasion that a general working session in either the Commons or the Senate had been routinely opened to the so-called electronic media of television and radio station recording equipment.

The cannabis bill, which at press time was still being discussed in the Senate, is expected to be presented in the Commons next fall.

The bill, which comes at a time of obviously-faded public interest in drugs although the subject still sparks oftentimes emotional responses from some public groups, would transfer cannabis from the Narcotic Control Act (which covers the so-called hard drugs like heroin and the opiates) to the less-stringent Food and Drugs Act. It covers prescription drugs, patent medicines, hallucinogenic chemicals such as LSD, and restricted drugs such as barbituates and amphetamines.

Under the bill, the first offence of simple cannabis possession would normally involve only a fine as punishment unless the individual convicted refused to pay the fine, in which case a short jail term could be imposed in lieu.

Senate rejects extra amendment

OTTAWA—The Senate has approved all of the amendments to the cannabis legislation that had been proposed by the Senate Committee on Legal and Constitutional Affairs.

But, following often-emotional debate, the Senate rejected a further amendment proposed by Senator M. Asselin that would have eliminated the word "give" from the legislation's definition of trafficking and thereby eliminated even the possibility of an individual's being charged with trafficking for passing cannabis to a friend.

Senator Carl Goldenberg, chairman of the committee which studied the bill and which itself had rejected the proposed amendment to the definition of trafficking, explained that the change (elimination of the word "give" in the definition of what would constitute trafficking) would "open the door to 'pushers' who would try to induce marijuana smoking by giving cigarettes to youngsters, that is, handing them out from time to time".

Senator Goldenberg said he was also influenced by assurances of police witnesses that it was unlikely a youngster would be charged with trafficking for just passing a friend a joint during a pot party.

Chafetz quits

(continued from page 1)

could in turn make recommendations to the Secretary of HEW.

The ADPA president reminded the membership that the appointment of Dr. David Matthews to be the new HEW Secretary is expected very soon.

"The naming of the new secretary will have a significant effect on the field of alcoholism, coming as it does at a time when the position of director of NIAAA is to be filled," he wrote.

Dr. Chafetz came to the government alcohol abuse program from Harvard medical school. He had specialized in the problems of alcoholism management for 18 years before coming to the predecessor organization of the present NIAAA in 1970.

The NIAAA was created in 1973. In the past five years, the budget for alcoholism programs in the US has risen from $17 million a year to about $150 million for fiscal year 1975.

Peer training

MILWAUKEE—Junior and senior high school students are being trained by state Parent Teachers Associations how to teach their peers about alcohol problems.

Richard Spoonster, national director of the PTA alcohol education project, said the Arkansas PTA was given a grant and is currently training teams of 10- to 11-year-olds on the problems of alcohol abuse. These children will have the major responsibility for educating their peers.

The same thing has happened in Arizona at senior school level, he said at the annual forum of the National Council on Alcoholism here. In the next year these students will be used to train junior high school students.

California votes 'no'—yet again

By SAUL ABEL

LOS ANGELES—According to the ancient Greek proverb, everything changes but change itself.

In the see-saw history of marijuana law reform in California, nothing can be expected but the unexpected.

This has been demonstrated once again by the recent defeat in the lower house of the State Legislature of a measure authored by State Senator George R. Moscone of San Francisco.

The measure would not have decriminalized marijuana, but would have sharply reduced penalties for simple possession, now among the harshest in the nation.

At present, simple possession in California may be treated as a felony, with maximum sentences of from one to 10 years imprisonment. Arrest and conviction are a lifetime blot on the individual's record.

Oregon, Alaska and Maine have "decriminalized" possession of marijuana for personal use. In addition, the Supreme Court of Alaska ruled recently that possession of marijuana by adults at home for personal use was constitutionally protected by the right of privacy.

The Moscone bill would generally make possession of one ounce or less a misdemeanor, subject to a maximum $100 fine. Arrest and conviction records would be automatically purged after two years.

Although the bill is in legislative limbo, it is not completely dead. A few days after the negative vote, the house approved a move by Assemblyman Alan Sieroty of Los Angeles to permit the measure to be reconsidered later, and also allowed him to place it indefinitely on the inactive file.

Sieroty, who in recent years has authored several similar marijuana liberalization measures, predicted the bill eventually will win passage.

In an interview with **The Journal** a few months ago, Senator Moscone forecast passage of his bill.

"I am confident we will have at last in California a sane and reasonable law on marijuana possession," he said (**The Journal**, March, 1975).

The measure hurdled formidable barriers in the Senate, winning approval by the Judiciary and Finance Committees, then by the full Senate on a vote of 21-16. It moved then to the traditionally less conservative Assembly, where it would be managed by Assemblyman Sieroty.

Signature by Governor Edmund G. Brown, Jr, was anticipated, since the Governor, while not specifically endorsing the bill, had stated he would support marijuana legislation in the pattern of a recent Oregon statute.

Despite strong and sometimes strident opposition, the bill cleared the Assembly Criminal Justice and Ways and Means Committees, and moved on to the Assembly floor.

There, it suffered a stunning upset, going down to defeat by a 38-34 vote. Switches by some legislators after the tally was announced, changed the official count to 37-36.

One explanation of the surprising setback for reform was the possibility of reprisals by conservative voters in upcoming elections. This apparently influenced Assembly Republicans, who opposed the bill unanimously, and also some Democrats especially sensitive to potential resentment among their constituents.

Alcohol liberalization in BC

(continued from page 1)

ocratic Party came to power in 1972.

The two pieces of legislation just introduced, however, go much further than the initial changes and could bring the province's liquor regulations more in line with those of Quebec's or some other provinces in Canada.

The Minister who introduced the legislation said it was an attempt to "debarbarize" liquor laws in B.C.

The Liquor Control and Licensing Act and the Liquor Distribution Act would hold the supplier of liquor to an intoxicated person liable if the person is injured or dies in an accident as a result of being drunk, and the amount that could be recovered is unlimited.

Many other changes in the legislation make access to alcohol easier, and increase the number of places of consumption.

It would be legal to drink liquor in designated outdoor places such as parks, and picnic areas and sidewalk cafes, as well as at sports events, and in mobile homes, trailers and campers.

Corner grocery stores would be allowed to sell beer and wine. Breweries, wineries and distilleries would be able to establish a store on their premises to sell their products.

The legislation also makes it possible for government liquor stores to sell beer and wine only and for stores to be established in remote areas of the province.

Other major changes include hours of sale and penalties for selling liquor to minors.

The present regulation that drinking establishments cannot open before 9 am or close later than 2 pm has been replaced to "best suit the public need and convenience."

Penalty for serving a customer under 19 years old would be increased from not more than $150 to not less than $500.

The extent of many of the changes will only be known when regulations are published and further decisions are made by the provincial cabinet.

Sale of beer and wine in small grocery stores still has not been approved by cabinet, in spite of the legislation, and is still subject to cabinet debate. Officials of the liquor administration are in Quebec studying its system of distributing beer through small stores.

Nor has a definite cabinet decision been made to allow breweries, distilleries and wineries to open on-premise shops.

There are also indications the government will leave it up to municipalities to decide whether they want outdoor drinking at parks, beaches or other areas.

Some municipal councils may reject outdoor drinking as too permissive and others might be influenced by the added litter problem outdoor drinking could entail.

Addicts drinking cough syrup

By ANNE MACLENNAN

TORONTO—Street use by narcotics addicts of hydrocodone cough syrup (Novahistex DH) is now "very widespread", according to an official of the Bureau of Dangerous Drugs.

Michael Rees-Evans, regional supervisor in Toronto for the Bureau, told **The Journal** that a second hydrocodone syrup, Congestex DC, is also being drunk by addicts, although to a lesser extent. He termed Novahistex DH "the current problem".

Use of the cough syrup seems partially to have superceded street use of tablets of hydromorphone (Dilaudid) which addicts crushed, dissolved and injected. Hydromorphone is a narcotic analgesic obtainable in several forms but used most often to treat profound pain.

The decrease in activity surrounding hydromorphone is thought to be the result of warnings earlier this year by the Bureau to all physicians, against getting caught in the double-doctoring web. In this, users move from one doctor to another asking each for a prescription. Pharmacists were also warned to watch for forged prescriptions.

In the case of hydrocodone, offences tend to involve thefts and forged prescriptions and pharmacists across the province have been warned accordingly, said Mr. Rees Evans. However, there continue to be thefts: When narcotics are stolen, so are supplies of hydrocodone, he said.

Mr. Rees-Evans suggested when there is a shortage of heroin, addicts look for other sources. If they are unable to obtain hydromorphone, they can achieve the desired end by drinking the cough syrup which is far more potent than any over-the-counter substance, he said.

Indeed, it has been reported that both hydromorphone and hydrocodone are more attractive than heroin because they are potent, in a form free of impurities, and devoid of some of the side effects heroin produces.

Researchers at the Addiction Research Foundation have noted that increased street use of both hydromorphone and hydrocodone became apparent in the last six to eight months of 1974. At that time, hydromorphone was reported to be selling in the street for from $20 to $25 per tablet.

That the drugs were increasingly popular was suggested by the increase in their importation, in double-doctoring, forgery of prescriptions, pharmacy break-ins, manipulation of physicians, and arrests for related drug offences.

According to Al Everson, head of the ARF's Narcotic Dependence Program, and Dr. Ruth Segal (PhD), a scientist in that program, in one albeit unusual case, a physician had indicated he was treating 30 to 40 patients with hydromorphone and wished to stop. After he was requested by them to refer patients to the program for assessment and treatment, only three patients presented.

The rest possibly found another source of supply or ceased to use and/or sell the drug, according to Mr. Everson.

Two of the three applying for assessment and treatment showed insufficient response to narcotic antagonist to be diagnosed as physically dependent.

US woman will study health care for women

WASHINGTON—A woman is to evaluate the appropriateness of mental health services for women.

Dr. Marcia Guttentag a Harvard University professor of psychology, will analyze statistics collected from state hospitals, community mental health centres and federal and private insurance programs, to try to establish the effectivness of services for female patients.

The work will be carried out in collaboration with the National Institute of Mental Health of the Department of Health, Education and Welfare's Alcohol, Drug Abuse and Mental Health Administration.

There will also be an investigation of results with women in such programs as Al-Anon, Alcoholics Anonymous, Weight Watchers, Recovery, Inc., and encounter groups.

The women will be queried as to why they sought these rather than more conventional health services.

Women who have had recent abortions or who have experienced crises such as divorce or the death of a husband will also be studied over a three-year period to determine to what extent existing facilities are meeting their needs.

Methadone: 'It only appears a failure'

By PETER MICHAELSON

OTTAWA—Methadone's declining popularity as a maintenance for heroin addicts is evidence that unrealistic expectations were made for the synthetic drug in narcotic treatment, says Dr. A. B. Morrison, director of the federal Health Protection Branch.

In spite of this declining popularity, methadone has not necessarily failed as a narcotic treatment, he said in an interview at the recent International Symposium on Drug Safety. It only appears to have failed because "some people expected unrealistic things of it."

Recent federal statistics show that several hundred fewer heroin addicts are on methadone treatment than was the case 15 to 18 months ago when the number of registered addicts on the maintenance program was at a peak of about 1,500, most in the Vancouver area.

At this peak, only about 10% of the country's addicts were on the treatment.

Dr. Morrison was critical of the way methadone was hailed in the United States several years ago as a salvation for heroin addicts, saying the present situation shows that "putting all your eggs in one treatment basket is foolishly simplistic".

Health Protection Branch officials never considered methadone maintenance more than a partial answer, he said. It is still the opinion of the Branch that methadone can be the best treatment available for older and better motivated heroin addicts who have the discipline to continue the daily dosage regimen.

Canada's methadone control program was introduced in a limited way in 1972 following recommendations of a special joint committee on methadone set up by the Branch and the Canadian Medical Association.

Like methadone maintenance programs elsewhere, it was plagued from the beginning by the diversion of legal supplies to an illicit market. In spite of this problem and other reservations about methadone the Le Dain Commission of Inquiry into the Non-Medical Use of Drugs recommended in 1973 that methadone maintenance should continue to be made available to as many opiate dependents as possible for whom it is appropriate.

The Branch is now studying possible reasons for the drug's failing popularity: Dr. Morrison said it may simply be that too many addicts "love the hussle of the streets and don't want to take treatment under disciplined conditions".

Dr. Morrison

DEA chief gets fired

By CHARLES MARWICK

WASHINGTON—John R. Bartels Jr., head of the US Drug Enforcement Administration since it was created almost two years ago, has been fired.

Attorney General Edward H. Levi has appointed Henry S. Dogin, a deputy assistant attorney general, as acting director pending the appointment of a permanent head of the agency.

The change in leadership of the DEA which was set up to coordinate the fight on illicit drugs in the US 23 months ago, comes at a tlme when the agency is under strong criticism for permitting lax policies and unprofessional conduct among its officials and agents. The DEA was formed by a merging of the Bureau of Narcotics and Dangerous Drugs and the Office of National Narcotics and Intelligence.

Mr Dogin, 40 years old, is a graduate of Columbia University Law School in New York and Cornell University in Ithaca, N.Y. Before he joined the Attorney General's office he was deputy regional administrator of the Federal Law Enforcement Assistance Administration in the New York office. He was an assistant district attorney in New York City before he joined the Federal government.

Mr Bartels had been criticized for not taking a firm hold of the agency, and for failing to resolve bureaucratic bickering among those who had worked for the previous organizations prior to the merger.

Furthermore, the agency has not, it appears, been able to stop the traffic in illicit drugs. Although there have been reductions in the "white heroin" traffic from Turkish and Oriental sources, there has been increased smuggling of so-called "brown heroin" from Mexico.

A report to the White House states that heroin addiction and other drug abuse results in 15,000 deaths and costs some $17 billion annually. Dr Robert L. DuPont, director of the National Institute for Drug Abuse Prevention, says heroin use is again rising and the number of deaths due to heroin overdose is at a record level.

The Senate's Permanent Investigations Subcommittee has been investigating operations of the DEA for the past six months. Public hearings laying out the results of this investigation are being held to review the total federal narcotics law enforcement effort and are intended to result in recommendations that will assist the government in combatting what has been described as a "coming narcotics epidemic".

Children sniffing gasoline fumes

(continued from page 1)

kowsky, "it causes a serious lowering of certain enzyme levels in the blood, which in turn leads to adverse physical effects: Brain damage, perhaps some others we haven't been able to pinpoint yet. In extreme cases, death."

Dr Fostakowsky's research was carried out under the sponsorship of the federal medical services branch in Winnipeg.

It was triggered by the arrival at the Health Sciences Centre of three Shamattawa children who were flown in "staggering, confused and suffering hallucinations" from gasoline sniffing.

Within the next few months the results of Dr Fostakowsky's findings will be published in the first medical paper to treat the problem of gasoline sniffing as a group study.

Working with Dr Fostakowsky were Dr Michael Scott, of the medical services branch in Thompson, and Brian Postl, a medical student at the University of Manitoba.

"Participation in the Shamattawa tests was on a volunteer basis, and there never was any doubt those 50 children showed much higher than acceptable lead levels in their blood because they were sniffing.

"We took testings from Shamattawa adults—the resident nurse, the chief of the band, others we knew weren't gasoline sniffing—and their lead levels all registered normal."

Dr Fostakowsky described the problem of gasoline sniffing among Indian children as one of isolation and circumstance, not race.

"We know glue sniffing (the generic term for sniffing any volative substance that produces a high, including gasoline) is a major and a growing problem among children.

"Native children are sniffing gasoline because it is the only such inhalant that is readily available to them.

"Compounding the problem is tetraethyl lead—the gasoline additive that is doing all the damage, almost as a side effect."

One of the researchers, Brian Postl, told of seeing children in Shamattawa walking around with a small can partly filled with gasoline—"sniffing as they went".

Psychologically and socially, gasoline sniffing has personal and community effects similar to drunkenness and the use of hallucinatory drugs. It makes children passive, lethargic, and disinterested in home or school activities. They are more apt to commit irresponsible acts or to injure or cause trouble for themselves or others. And in some cases they may react with violent or other anti-social behavior.

"The children's parents and the band as a whole see the problem as a major one," said Dr Fostakowsky, "but they don't know what to do about it.

"The chief and his council approached the resident nurse while we were there. They asked her what they could do. She didn't have any answer for them."

Dr Fostakowsky sees Shamattawa as typical of the problem of isolated native communities throughout the north.

There is no place to go. Nothing to do. "The kids don't know who they are. Or what they are. Or why they are there. So they sniff up on gasoline.

"For a few hours or a few days, whenever it gets to be too much for them, they lose themselves. Or become someone else. Or find their hallucinatory Shangri-La.

"When we eliminate our native children's need for this, then maybe we'll eliminate their need for sniffing up on gasoline."

There is a positive side to the problem.

Dr Fostakowsky said the type of lead poisoning caused by gasoline sniffing can be treated without harmful after-effects if it is caught at a reasonably early stage.

Spouses of alcoholics

join their partners in hospital

AN EXPERIMENT in inpatient hospital treatment of families suffering from alcohol abuse has been reported by a team from the department of psychiatry and behavioural science at George Washington University.

Assistant professor of psychiatry Peter Steinglass referred to the program as a "fascinating therapeutic venture . . . for both treaters and treated".

The core of the research program, a 10 day hospitalization period for both husband and wife, was designed to permit simulation of home behavior—a homelike atmosphere, with alcohol freely available during the first seven days of hospitalization.

MILAN KORCOCK
reports
from the
annual meeting
of the
American Psychiatric
Association,
Anaheim, California

As the family units went about their business of living, shopping, preparing their own meals, arranging recreational activities, and undergoing mandatory and voluntary therapy sessions, the therapists were able to gain insights into the family dynamics that in many cases precipitated abusive drinking behavior.

"The program not only does not insist on the usual abstinence model of treatment but actually suggests that intoxicated behavior can be utilized by the therapist as an adjunct to treatment", said Dr. Steinglass.

"And then, instead of viewing the individual alcohol abuser as the problem, therapy is directed at the couple."

In one specific case a husband was constantly faced with the prospect of returning home to a wife who by late afternoon had consumed a bottle of scotch, was depressed, histrionic and often talked about suicide.

But it was found by the therapists as well as other couples in the group, that it was only when the wife was so intoxicated that he, the husband, showed any real affection toward her, and often these drinking bouts ended in the couple's making love.

When this phenomenon was defined to the couple, the husband actively worked at reducing his overinvolvement with his wife during her drunken state, and she worked at being more affectionate and receptive during her sobriety.

The program was divided into three phases: an initial two-week outpatient phase in which groups met for three sessions per week; a 10-day inpatient phase when three couples were simultaneously admitted; and finally, a post-hospitalization outpatient phase.

In the inpatient phase, the couples were given many options for spare time activity, were given access to ancillary treatment opportunities (such as viewing videotapes of therapy meetings), and were required to attend only one daily 90-minute multiple couples group therapy session. Despite this freedom, they involved themselves prodigiously in marathon therapy sessions each evening, in viewing tapes, and in interacting with each other to discuss problems.

The groups were run by two psychiatrists on an alternating schedule.

It appeared the inpatient week divided itself into two sections: an initial three- to four-day period of heavy drinking, and a subsequent five- to six-day period when drinking diminished to a trickle, said Dr Steinglass.

By the third or fourth day, observers were able to identify repetitive and predictable patterns of consumption from couple to couple, despite the brief hospital stay.

Each couple established its own particular, distinguishable cycle.

Dr Steinglass noted that the five- to six-day period, in which drinking usually diminished dramatically, was a period of intense therapeutic effort with the couples immersing themselves in work.

"The mood of both patients and staff during the inpatient week was optimistic," he said. "There was often renewed optimism about the marital relationship and the sense that they were taking positive action to alter their lives.

"One couple in fact, celebrated their 25th anniversary on the ward and requested reservations for their 50th".

Dr Steinglass admitted the program is still highly experimental in nature and said it would be hazardous to generalize too broadly the impact of this type of program on less highly-motivated couples.

"The program recruits middle class, intact couples who display a substantial degree of economic and interactional stability . . . and asks these couples to accept inpatient status at a state hospital facility that justly or unjustly enjoys an ominous reputation in the suburban communities from which these subjects have been recruited.

"But initial observations support a position of preliminary optimism about this treatment approach."

The inpatient hospital experience definitely allowed the therapists to gain a clear-cut clinical understanding of the relationship between drinking behavior and the couples interactional life, said Dr Steinglass. And this understanding was achieved in a remarkably short time.

"We would suggest . . . that the hospitalization of a couple or an entire family with open access to alcohol in the therapeutic situations may provide information that will give momentum to change in a previously intractable drinking situation."

Defining the alcoholic personality

Survey allows improved treatment

IN DEVELOPING a profile of the typical alcoholic, there is always one more thing to add. No single definition ever seems complete.

As Dr. Melvin Selzer, professor of psychiatry, University of Michigan, puts it: "A simplistic approach to alcoholism obscures the fact that alcoholism is not a unitary disorder, but an end point for a number of syndromes."

Given this diffusion of focus, it becomes more and more critical to define clusters of characteristics which contribute to a better understanding of the alcoholic and thus, to a more rational approach to his treatment.

Dr. Selzer has refined a questionnaire to screen out psychological and social characteristics, and personality and behavioural differences of alcoholic populations, and allow for a more precise approach to their treatment.

He applied the questionnaire to 289 alcoholic men in treatment, and compared the results to answers of a control group of 302 non-alcoholics.

The differences between the two groups offer illuminating insight into the makeup of the alcoholic, and into his specific treatment needs.

This is how the data, refined from the questionnaire, breaks down:

Defensiveness: Alcoholics appeared more likely to acknowledge unfavorable aspects of themselves than did the control group, and were less prone to covering up unfavorable data about themselves.

Reasons for Drinking: Alcoholics were more prone to drink when worried, depressed or tense. They drank to relax and to overcome shyness.

While controls also drank for relaxation, relatively few did so for tension relief.

Effects of Drinking: "When you drink, what does alcohol do for you?"

The alcoholic group reported significantly more troublesome effects than did the controls. They were more inclined to respond that drinking makes them depressed, lose control, get in trouble with each other.

The controls replied that drinking made them feel "more relaxed, happy, less concerned about problems."

Leisure Activities: Except for activities involving drinking with friends, alcoholics are not too involved in society. The most pronounced differences between the two groups were the non-alcoholics' variety of non-drinking activities with friends.

Coping with Tension or Depression: Subjects were asked: "How often do you do each of the following when you are depressed or nervous or tense?" The list of possibilities included taking tranquillizers, smoking a great deal, having a drink, physical activity, going to a movie, thinking it over, talking the problem over with someone, and talking to others but not about the problem.

Alcoholics resorted much more frequently than controls to taking tranquillizers and drinking and smoking in order to cope, whereas the controls tended to use the physical options and to talk problems over with others.

Self Esteem: In assessing self-worth, self-satisfaction, and feelings of success, alcoholics were significantly below the controls.

Depression: Using both the Zung Self Rating Depression Scale and the Depression Adjective Check List, alcoholics showed dramatically more depression than did the general population.

In fact, prevalence of depression among this group turned out to be one of the most significant findings of the survey.

The surveyors found that 33% of the alcoholic population, as compared to 6% of the control group, suffered depression of clinical severity.

These assessments were drawn against measurements related to mood (blue, crying, tired for no reason, poor appetite, trouble sleeping), or words related to depressed states (sad, failure, sunk. . . . merry, eager, whole).

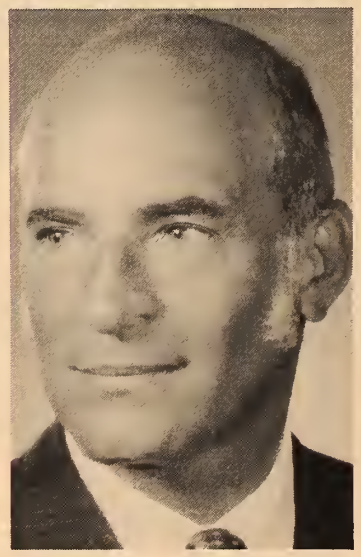
Death Wishes: Responding to questions about suicide, 43% of alcoholics admitted they had at some time felt like taking their lives, compared to 22% of the controls. Asked whether they had felt this way within the past 12 months, 30% said they had, compared to 14% of the controls.

Still in respect to committing suicide, 21% of the alcoholics said they had thought about it "seriously" in the previous year, compared to 6% of the control group. And 5% of the alcoholic group, compared to 1% of the controls, had actually attempted suicide one or more times during the previous year.

Aggression: As could be expected, alcoholics showed a far more aggressive stance than did controls. They were more prone to apply action to their feelings.

Alcoholics averaged 0.46 fights during the year and 0.98 episodes of throwing and breaking objects, versus 0.14 and 0.57 for the control group.

Paranoid Thinking: Both groups were faced with questions and statements such as: "I commonly wonder what hidden reason another person may have for doing something nice for me," or they were asked to respond to questions such as: How often do you feel (1) that someone is trying to spoil things for you? (2) that someone holds a grudge against you? (3) that things are rigged against you (4) envious of other people?



Dr. Selzer

In all respects, alcoholics displayed a significantly higher paranoid index.

Seeking Help: Faced with the question: "If you had a drinking problem, which of the following sources would you turn to for help?" both alcoholics and controls gave some surprising answers, none of them gratifying for psychiatrists.

For example, 72% of alcoholics favored turning to AA, 66% said they would go to a doctor, and 66% to a hospital.

Among controls, 63% said they would go to a doctor, 59% to AA, 56% to their wives, and 45% to their friends.

Only 31% of the alcoholics said they would favor going to a psychiatrist for help, and the same number said they would favor going to a minister. Among controls, 31% said they would seek help from psychiatrists, and 34% would seek help from their ministers.

In analyzing the data from the questionnaires, Dr. Selzer said:

- Drinking for the alcoholic appears more purposeful, more goal-oriented.
- Drinking for the alcoholic is not only quantitatively different, but different in terms of motivation and urgency.
- Alcoholics do not find gratification in the leisure pursuits which others find fulfilling. Drinking with others is often their only leisure activity. Alcoholics show a heavier reliance on drugs and alcohol at the expense of more cerebral, physical, or interpersonal pursuits.
- That a full one-third of the patients in the alcoholic group suffer from serious depression may be revealing in terms of a deficiency in current alcoholism treatment programs.
- In respect to aggressive feeling, aggressive acts, and paranoid thinking, alcoholics are quite different from non-alcoholics and from each other, and these differences should not be overlooked in treatment programs since they may contribute to the onset and perpetuation of the patient's alcoholism.
- Alcoholics are most needful of treatment programs designed to alter counterproductive leisure and coping patterns.

Alcohol— THE drug of violence

DESPITE THE broadening spectrum of drugs being implicated in criminal activities, alcohol remains the single drug most often linked to both physical and sexual assaults, Dr. Jared Tinklenberg of Stanford University, told the meeting.

Reporting on the drug-using patterns of 161 imprisoned male youths in one California facility, Dr. Tinklenberg said almost all of the juveniles had used a wide variety of psychoactives including secobarbitol, marijuana, amphetamines, volatile compounds, LSD, and related psychedelics, often in addition to alcohol.

In 74 cases of physical assault occurring while under intoxication, alcohol, either alone or in combination, was implicated 56 times, secobarbitol 21, marijuana 19, and amphetamines 6.

Of the 40 cases of sexual assault occurring while under intoxication, alcohol was implicated, either alone or in combination, 31 times, marijuana 17 (five linked to marijuana alone), secobarbitoal 4 times.

Dr. Tinklenberg said the trend revealed by this study is analogous to most studies investigating the relationship between drugs and crime in adults.

That both alcohol and secobarbitol are linked with the same phenomenon of physical aggression might be explained by the fact that both these central nervous system depressants share many pharmacological and clinical characteristics.

"Drugs whose predominant actions induce central nervous system depression seem to be associated with violence characterized by diffuse irritability and an exaggeration of normal aggression," said Dr. Tinklenberg.

"Psychoactive agents that primarily evoke CNS stimulation or perceptual alterations are more frequently linked with bizarre, delusional violence which is often out of character for the assailant."

The violent episodes occurring in relation to marijuana use were invariably transient, said Dr. Tinklenberg, and followed the consumption of preparations more potent than was typical for the user.

Subjects of this study at the Northern California Youth Facility were jailed between January 1971 and December 1974.

Flying 'high'

By MILAN KORCOK

MARIJUANA, as it is normally used in a social context, has been shown to impair significantly the psychomotor responses of professional airplane pilots, with some of the effects lasting up to four hours after smoking.

Reporting on a series of experiments in which marijuana-smoking pilots were tested on a flight simulator, Dr. David S. Janowsky of La Jolla, California, said "social" marijuana smoking was not an uncommon practice among pilots, some of whom reportedly had flown aircraft while high on the drug.

Subjects of the study, done at the University of California at San Diego, were seven professional, and three private, male pilots, all of whom had been smoking marijuana socially for several years.

Most of the subjects felt flying was a more challenging task while intoxicated, and they believed they failed to compensate adequately for the drug-induced deficiencies.

The entire group showed a significant increase in pilot errors related to heading, altitude, and deviation from the assigned pattern, when tested 30 minutes after smoking the controlled dosages.

The group had an average major error rate of 2.9 per test flight series while intoxicated, compared to an average 0.4 while on placebo.

(Major errors, would have involved gross navigational and altitude deviations: The plane might have got lost, run out of fuel, or stalled.)

Decreased flying ability was apparent for most of the pilots two hours after smoking, said Dr. Janowsky, and performance did not return to baseline levels until four hours after the smoking test.

(The testing was done following the use of marijuana—2.1% Delta 9 THC at a dosage of .09 gr. per KG—smoked in a pipe. The pilots were used as their own control group.)

"The deficiencies noted in pilot performance probably reflect marijuana's ability to affect memory, skill, concentration, time, and orientation in three-dimensional space, as well as the performance of multiple complex tasks," said Dr. Janowsky.

As revealed by the flight simulations, subjects often forgot where they were in a given flight sequence or had difficulty recounting how long they had been performing a given maneuver, in spite of the presence of written instructions and a stop watch.

Pilots also seemed to concentrate on some variables to the exclusion of others. Several pilots, for example, noted that following a momentary lapse, they could not tell how long they had been flying or where they were located in the flight sequence.

Following this lapse, they seemed to overcontrol or oversteer in an attempt to compensate for their earlier lapses.

"At times," said Janowsky, "subjects exhibited a complete loss of orientation with respect to navigational fix, resulting in grossly unpredictable flight performances."

The pilots in this series performed a memorized flight sequence and had the instructions for the pattern in front of them at all times. In actual flight situations, instructions come sequentially from an air traffic controller and must be accurately noted and repeated by the pilot.

"We believe pilot performance under such circumstances would be even more adversely affected by marijuana intoxication," said Dr. Janowsky. Furthermore, the experiments did not measure the effects of altitude and pressure change on the pilots, nor did they test such parameters as airspeed control, angle of bank, or rate of control movement.

Specific tests involved four consecutive four-minute holding pattern sequences, which included manoeuvers typically encountered in instrument flight (straight and level flight, turns, three dimensional maneuvering, radio navigation).

The first and fourth four-minute sequences consisted of a standard holding pattern, the second and third sequence consisted of a standard holding pattern modified by incorporating altitude changes. Also, a level of turbulence was added so the pilot would have to continually manipulate the controls to compensate for its effects.

Dr. Janowsky said the effects of marijuana on flying performance may represent a rather sensitive indicator of the drug's psychomotor effects.

"The use of trained pilots to perform a complex psychomotor task may be a sensitive 'bioassay' of marijuana's effects on cognitive functioning which has implications beyond those obvious to the safety of the airplane pilot," said Dr. Janowsky.

Dr. Janowsky was speaking at the annual meeting in Anaheim, California, of the American Psychiatric Association.

Dr. Janowsky

Marijuana at the controls? It does happen.

International alcohol control - urged by Finnish expert

By JEAN McCANN

HELSINKI—Alcohol needs to be under international control by the United Nations, just as narcotics are, because it is "the drug accounting for more harmful effects than any other", Kettil Bruun of Finland told the International Institute on the Prevention and Treatment of Alcoholism here.

Such control, he said, need not be modelled after the present narcotics control system, and in fact "control" has to do with all the measures which influence the availability of a drug, not just police action or criminal policy.

Such international control, he said, may have a better chance now of coming about than formerly.

"First, the notion that the overall consumption level has a bearing on the number of heavy consumers, and that heavy consumption is connected with risk to health, has a bearing on the general understanding for a need of a control policy.

"Second, the overall rise in consumption during the 60s is a matter of concern and the fact that this rise is related to structural changes in production, adds to this concern.

"Third, the fact that international trade in alcohol is going up, together with an increased tourist trade in alcohol, and the establishment of beer production firms in, for instance, Africa, are all facts which cannot be ignored by those who are supposed to work for the improvement of public health."

"Fourth, the statistics now available are far from satisfactory, and we ought to remember that in the field of narcotics the development of statistics proved to be of strategic importance."

Bruun, of the Finnish Foundation for Alcohol Studies, said alcohol was not originally brought under international control, as other drugs were, because England and France were not interested. As members of the League of Nations at that time, England was more interested in opium control, and France in protecting her wine industry.

"The US was not a member of The League, and this meant that no powerful country was in favor of prohibition. Against this background, it is of no surprise that the interest in alcohol in the Permanent Mandates Commission weakened, and this trend was reinforced by the abolition of prohibition in the US."

At the same time, he said, the US got internationally involved in drug control through a special body called the Permanent Opium Board, and in other ways, although not a League member.

When the United Nations was formed, he said, the League emphasis on drugs to the exclusion of alcohol was continued.

The disparity in interest continued and was prolonged by several factors, he said. These included:

- "unwillingness to accept the dependence-producing properties of alcohol, and the exaggeration of the harmful effects of the classical narcotics;
- "the development of the idea of national versus international control. Western products like alcohol and pharmaceuticals were thought to be more conveniently controlled nationally;
- "the developmenent of a jargon which, by employing such phrases as 'problem countries', obscured the real issues;
- "the development of a pharmacological-legal framework, rather than a sociological-anthropological-medical one;
- "the search for the alcoholic personality as an explanation of alcoholism, in contrast to the dependence liability of the other drugs, did add to the imbalance."

He laid considerable blame for this situation on unrealistic attitudes in the United States. "Let us not in the area of international control replicate the mistake of the US—to make control synonymous with prohibition, and altogether neglect studies of alcohol control because of this attitude."

Bruun told the international meeting here that he drew his conclusions from three works. The first was a Finnish study in which he, Lynn Pan and Ingemar Rexed participated. Called The Gentlemen's Club, International Control of Drugs and Alcohol, it will be published in August by the Chicago University Press. Another publication due to come out this summer called Alcohol in Colonial Africa was also involved, in his research.

The third publication is Alcohol Control Policies and Public Health, prepared under contract with WHO/Euro by the Finnish Foundation.

"The Addiction Research Foundation in Ontario, as well as individual researchers from various countries, are also participating", he added. He said the second draft of the report will be discussed in August in Toronto, with the aim of getting it published next year.

Cookies from the Hope House oven

At Hope House Bakery

Therapy in the kitchens

By JEAN McCANN

CLEVELAND—There's nothing like kneading dough and shaping bread loaves when you're trying to get your own life into shape.

So says a group of alcoholic residents of Hope House who have gone into the bakery business.

Where once these women relied on alcohol to get through each day, they now count heavily on the productive hours they spend in their own bakery store. Each weekday they turn out some 200 loaves of rich natural bread made with fresh eggs, fresh butter, and organically-grown wheat flour. They also produce cinammon raisin kuchen, cookies, and brownies made with carob instead of chocolate.

"I love it", said one woman, gingerly extracting a tray of hot loaves from an oven. "It sure is different than teaching school, though."

Another alcoholic, a high school student who used to drink a fifth of liquor a day, is gaining confidence in herself through working as a baker. "I'm really surprised I can do this. It's affected my school work, too. I think I can do things, now."

In charge of the Hope House Natural Bakery at 7303 Detroit Avenue, is Sally Kieth, a recovering alcoholic who learned the bakery business in New York.

Not only is baking bread therapeutic, she says, but it's not "make work" therapy. It's part of real life.

Meanwhile, the women are learning to cooperate with each other, and to give and take directions, says Sister Nancy, a former teacher and principal and now director of the non-sectarian facility.

"It all began in a natural kind of way," Sister Nancy told **The Journal** in an interview in her small office in the reconverted apartment building a few blocks from the bakery-store and where 12 alcoholic women live.

"Our first aim was to put good bread on our own table, so we began baking bread in the house here. When people outside began asking for it, we did start selling it from here. But everything had to be done by hand. When the store became available, we were able then to acquire some regular bakery equipment and to turn out a larger volume. An anonymous donor pays the rent for the store."

The aims? They are "not only to provide useful work for the women here to help them attain skills and independence, but to help Hope House to become more self-supporting."

The idea of Hope House grew in the mind of Sister Nancy when she took a course on "other ministries religious women could get involved in". She learned about the problems of treating alcoholics but found there were no non-hospital treatment centres for women alcoholics in the Cleveland area, and few elsewhere.

She wanted to start something and her religious superior urged her to begin.

The United Labor Agency backed the project and further support came from other local organizations, businesses and industries.

Sister Nancy plans soon to acquire another building near Hope House, to allow treatment of more women on a longer term basis than the usual eight weeks.

"What we have here is a facility willing to help those women who want to be helped. Admission is on the basis of an intake interview, and we will take women who don't live in Cleveland. We have no restrictions on age, either. We've had girls 16 and 17 years old and women as old as 69." Those who can are asked to pay the $18 daily cost.

Hope House has no psychiatrists or psychologists on the staff. The program is based on the twelve principles of Alcoholics Anonymous.

"For the first eight weeks, we don't have the women hold outside jobs, which we learned by bitter experience not to allow. We also keep them in the house here for their first week with us. When they come in they're usually physically run-down and in a fog. It's a big thing for them just to put their pajamas on, take a shower, or come downstairs for meals."

As the weeks go on, the women participate more in the running of the house.

"We also have weekly sharing groups, which is a kind of group therapy session, in which we talk about our difficulties and the past, as well as the impact of reality."

The program, says Sister Nancy, is based on spiritual principles, rather than professional expertise. The staff, which includes one other religious sister, also includes recovering alcoholics.

Those admitted must be physically able to negotiate stairs, and not need "medical, custodial, or psychiatric care". Once discharged, they may continue to participate in some Hope House programs.

As the brochure for Hope House explains: "The aim of Hope House, more than sobriety, is total life change. Getting sober is not the answer to the problem: Learning how to stay sober is where the work begins. A woman's life during the time she is involved with alcohol revolves only around that precious bottle. She gives little thought to responsibilities, jobs, or her family. Hope House operates as a large family where women begin to live a life without booze."

Hope House offers more than sobriety

BC drug commission doubles expenditure

By PETER THOMPSON

VANCOUVER—Budget estimates of the New Democratic Party government show the British Columbia Alcohol and Drug Commission is expected to spend some $5.2 million this year, compared with about half that amount last year.

This is the first time the commission has been formally integrated into the provincial government's budget. Last year, much of the commission's financing came from interest earned by the Drug, Alcohol, and Cigarette Education Prevention and Rehabilitation Fund set up by the previous Social Credit government of W. A. C. Bennett.

The commission operates as a type of holding company for drug programs in the province. Instead of running the programs itself, the commission finances programs of local community groups.

Local groups are responsible to the communities they serve, in many cases, but are dependent upon the commission for funding. In return for funding, the commission insists programs meet certain standards, provide a certain range of services, and that people who provide the services are accredited by the commission.

The commission's report for 1974 expresses the same scepticism and caution as the special report issued about one year ago covering the first months of the commission's existence.

"Discussions with our counterparts in other provinces of Canada re-affirm our belief that expedient solutions are no solutions at all. Sophisticated institutions and glossy pre-packaged programs do not, in the long run, have any profound effect on a problem which arises from a host of causes basic to the individual and the community," the 1974 report says.

Though the report echoes the hard-headed pessimism of the special report of last year, it does not wade into the arguments of those who oppose the commission as the special report did.

The special report, known in the commission as the "silver bomb" because of the color of its cover and contents, was a no-holds-barred attack on the commission's enemies.

In contrast, the 1974 report is in the style of most annual reports, a dry review of the institution's activities for the year.

The report says that during the year the commission formulated and dropped plans for a training centre to be located in Vancouver.

"One training centre, regardless of quality, could not supply the needed people, or provide training opportunities of sufficient relevance to be immediately useful beyond a small area of the province," the report says.

As partial substitutes for the training centre, the commission produced two documents, **Manual for Staff Accreditation** and **A System of Care and Program Definition**, to describe what needed to be done.

The Narcotic Addiction Foundation and Alcoholism Foundation were chosen, as the largest agencies in the province, to begin training and staff accreditation, the report says.

The staff accreditation manual tries to solve the old dispute of the role of professionals and non-professionals in drug programs.

It is unreasonable and undesirable to have all treatment programs staffed by professionals only, the manual says. Significant contributions have been made in the drug treatment field by many concerned, competent people who are untrained "or more accurately, who do not possess membership in any of the professional guilds," it says.

"It is also true, however, that inestimable damage has been done by concerned people, whose only qualifications have been good intentions and a sentimental need to help.

"The debate about who should treat whom for what, usually degenerates to the polarization, professional versus non-professional. This is a tiresome debate and is usually a thinly-disguised conflict between groups who are trying to protect their status on the one hand, or trying to get a piece of the action on the other.

"The real issue is to be found in the question, 'Is there any advantage of a trained, helping person over an untrained, helping person?' The answer is an unequivocal 'yes'."

BC manual termed advert for drugs

VANCOUVER—The British Columbia Alcohol and Drug Commission has come under heavy political fire over an information manual on alcohol and drugs.

Opposition members of the British Columbia Legislative Assembly have attacked the publication as biased and an advertisement for drugs.

The charges were made by Dr Pat McGeer, former leader of the provincial Liberal Party and head of the division of neurological sciences at the University of BC; and R. H. McClelland, health spokesman for the Social Credit Party.

They opposed sections in *A Professional Guide to Alcohol and Drug Information* prepared by the commission's education department for the use of teachers, nurses, doctors and other professionals.

The introduction says the material is primarily pharmacological and designed to help the reader to react accurately and sensitively to questions about drugs.

Criticized most severely was the section on marijuana.

"Typical subjective effects are mild stimulation or exhilaration, followed by a pleasant feeling of well-being, during which the user may appear introspective or tranquil," the cannabis section says.

"Changes commonly reported include increased or decreased sociability and talkativeness, hilarity, increased flow of ideas, enrichment of sensory experience, heightened imagination and feelings of enhanced creativity and spontaneity.

"There may be changes in visually perceived relationships and time may seem considerably slowed. There is usually, but not always, an increase in appetite or enjoyment of food.

"Although it is generally agreed that cannabis has little aphrodisiac effects, many users say they enjoy sex and other intimate human contact more when 'stoned'."

The manual goes on to list some unpleasant effects of cannabis including anxiety, fear, nausea, irritability and depression.

It is the lack of mention of possible brain damage that particularly upset Dr McGeer. He told **The Journal** that the bibliography at the end of the marijuana section omits any literature indicating deleterious effects of marijuana use.

The manual, he said, emphasizes the pleasure and minimizes the hazards of using cannabis. "The effect would be to increase curiosity rather than deter," Dr McGeer said.

Unlike heroin addicts

Fertility of methadone users is suspect

SECONDARY SEX organ function of men in methadone maintenance programs is clearly below that of both heroin addicts and drug-free controls, according to a study from Washington University School of Medicine, St. Louis.

Judging by ejaculate volume and ejaculate composition, neither seminal vesicles nor prostate of methadone users perform at normal levels, Dr Theodore J. Cicero reported.

As for primary sex organ function, the testes appear to work normally in that they produce adequate amounts of sperm. However, sperm motility is markedly reduced, as are serum testosterone levels.

The difference, Dr Cicero said, seems to be attributable to methadone use per se, since heroin addicts seem to have only slightly impaired sex organ function, even when they have been on drugs longer.

To evaluate the effects of heroin and methadone on male sexual function, Dr Theodore and his colleagues studied 29 methadone users (average age 29, on drugs nine years); 16 heroin addicts (average age 32, on heroin 12.9 years) and 43 controls (average age 24). All had to meet certain medical criteria—good health; no pertinent defects, injuries, or infections; no VD; no abuse of other drugs.

The methadone users had all been in the program for at least three months, and were taking doses of more than 25 mg daily. The men taking heroin had been addicts for at least 2½ years, and their current "habit" was at least three months old.

All subjects answered a questionnaire covering their medical, sexual, and drug-use histories. Researchers attempted to obtain 10cc of blood from each man, though the veins of several individuals, particularly in the methadone group, proved too badly clotted, Dr Cicero said.

Three of the methadone clients, one control, but none of the heroin addicts, were unable to produce a masturbated sample of semen.

The sexual histories revealed that both methadone and heroin users experienced "substantial difficulties with many aspects of their sexual behavior and function, particularly delayed ejaculation, impotence and failure to ejaculate," Dr Cicero reported.

All of the heroin users and all but one of the methadone users reported substantially less desire for sex when on narcotics than when they were drug-free. Whereas controls averaged 12 ejaculations per month, the methadone clients reported five and the heroin addicts less than three.

The heroin users said sex took too much time away from drug-seeking, and that it reduced the "high" they got with heroin.

Methadone users, in contrast, reported they were unable to obtain or maintain an erection during intercourse. In addition they experienced a decrease in pleasurable sensations. Prior sexual abstinence averaged 11.4 days for methadone users and 12.9 days for heroin addicts, but only 3.5 days for controls.

Volume of ejaculate, which is mostly the product of the seminal vesicles and the prostate gland, was approximately 50% less in methadone users than in controls, and 40% lower than in heroin addicts, the St. Louis team found.

Even though absolute volume increased up to a three-day abstinence period, then levelled off, in both methadone and control subjects, the volume of the methadone users never exceeded 50% of the controls.

Concentration of fructose and of citric acid, which are selectively secreted by the seminal vesicles and prostate, respectively, were substantially reduced in methadone clients compared to both heroin and control groups.

In heroin users, ejaculate volume and citric acid levels were lower than controls' levels, but the differences were not statistically significant.

The Washington University researchers found no significant correlation between methadone dose and any measure of secondary sex organ function. The only correlate with dosage appeared to be longer prior abstinence.

The sperm count, a measure of testicular function, was the same in all three groups for men who reported two days or less of sexual abstinence. When abstinence exceeded three days, the sperm count of the methadone clients was significantly higher than controls. It was also higher in heroin addicts, but not with statistical significance.

In contrast, sperm motility was substantially below normal in both methadone and heroin groups. While 64% of control sperm showed progressive motility, the rate was only 31.6% in methadone and 33% in heroin users.

Similarly, serum testosterone levels were significantly lower in methadone clients than in either heroin users or controls. Contrary to some reports, the St. Louis team found no meaningful correlation between daily methadone dosage and testosterone levels.

In view of the methadone users' extremely low ejaculate volume and low sperm motility, they might be expected to have fertility problems, Dr Cicero stated. Indeed, none of the methadone clients had conceived any children while they were taking methadone, although as a group they had previously fathered a total of 53 children—and were still relatively young men.

The heroin users had even less frequent sexual activity than the methadone users. Nonetheless, 31 of the 47 children they had fathered were conceived while they were actively using heroin.

"Based on our limited sample size, we do not consider our results in any way conclusive," Dr Cicero cautioned. "What is clear is that the fertility of methadone clients is suspect."

LYDIA WOODS SCHINDLER reports from the 37th annual scientific meeting of the Committee on Problems of Drug Dependence of the US National Academy of Sciences, held in Washington, DC. More next month.

Sex function unaffected by pot

DOES MARIJUANA impair sexual function? To the two studies already on record—with divergent views—Dr Cicero and his colleagues weigh in on the "no" side.

The Washington University team compared volume of ejaculate and testosterone levels in controls, methadone users,and heroin addicts further subdivided into three groups—those who did not smoke marijuana; those who smoked one to four joints a week; and those who smoked more.

Marijuana, they concluded, had absolutely no effect on any measure of primary or secondary sex organ function. For that matter, neither did alcohol.

BRAIN CHANGES ON METHADONE ARE HARMLESS

LONG-TERM METHADONE maintenance is not guilty of causing neurological dysfunction, a University of Chicago psychiatrist has declared.

Although some methadone clients may show minor electroencephalographic differences, these do not correlate with clinically significant neurological abnormalities.

Dr Edward C. Senay and colleagues compared 25 members of a methadone maintenance program with 25 former addicts, now abstinent, who had not used heroin or methadone for at least one year prior to the study. Both groups were in their early 30s, on the average, and had taken heroin for an average of 10½ years.

The methadone subjects had been in the program from 2 to 3½ years, and had abstained from illicit drug use for at least the previous six months, as shown by urinalysis.

Of the 25 people in the control group, 22 were either entirely normal or had only headache, essential tremor, or EEG "within the limits of normal". The other three gave evidence of minor EEG abnormalities.

Similarly, 22 of the 25 subjects in the methadone group were either entirely normal, or had only headache, trauma, previous retinal detachment, benign positional vertigo, or EEGs considered within the limits of normal. Two had abnormal EEG findings: One had acute alcohol intoxication; the other was suspected of having a systemic disease. There were no EEG findings characteristic of the methadone group.

The third abnormal subject had a mild subjective decrease to pin and touch in glove distribution on his hands.

"If this instance is indeed attributable to methadone," Dr Senay said, "its low incidence and very mild degree are both impressive."

Heroin's acute/chronic effects differ

CHRONIC EFFECTS of heroin are not the same as the acute effects, and the difference between the two may in part explain an addict's compulsion to continue taking the drug.

Reporting a study from Harvard University and the Drug Addiction Research Unit at McLean Hospital, Belmont, Mass, Dr Steven M. Mirin explained that early in the addiction cycle, the effects of heroin are positive: It relieves tension and produces euphoria.

As the cycle progresses, however, and more drug accumulates in the body, there is a marked shift toward negative effects—dysphoria, increased psychopathology, motor retardation and social isolation.

Nevertheless, even after an addict develops tolerance, heroin still retains its ability to induce a short-lived good mood: A shot of heroin can cut through the dysphoria and make the addict feel better temporarily.

Dr Mirin, who is clinical director of the Research Unit, and his colleagues, Dr R. E. Meyer and Dr H. B. McNamee, set up their study to approximate an addict's street experiences. They allowed subjects access to increasing doses of intravenous heroin on a variable-dose, variable-interval schedule of their own choosing for 10 days.

The amount of heroin that could be self-administered at any one time was limited only by the number of days or prior use, to accommodate tolerance, and the time elapsed since the last dose, to control cumulation, he explained. A dose increased from 0.5 mg on Day 1 to 5 mg on Day 10.

The subjects were 14 men over the age of 22 years, with at least a two-year history of regular heroin use, and two or more unsuccessful attempts at rehabilitation.

To "earn" the heroin they had to meet a work requirement, accumulating purchase points which they could then exchange for heroin at a fixed rate. All of them, Dr Mirin noted, were able to accumulate enough points to purchase the maximum amount available on any given day.

Over the 10-day study, the 14 subjects injected a mean of 54.9 doses of heroin. Mean plasma morphine rose steadily throughout the 10 days, and the subjects appeared increasingly intoxicated, demonstrating diminished responsiveness to the environment, nodding, and a generalized withdrawal from social contact.

As measured by psychiatric evaluation scales, the first days of heroin self-administration were marked by a significant increase in elated mood coupled with a marked decrease in somatic concern, anxiety, tension and guilt. At the same time, the subjects grew much more belligerent and negative than they had been during the preceding drug-free period.

As the addiction cycle wore on, there occurred a distinct shift in the subjects' mood and clinical status, Dr Mirin reported. Instead of relieving anxiety and depression, heroin began to elicit increased psychopathology and dysphoria. Belligerence and negativism increased, "and could readily be discerned in subject-staff interaction as well".

"Despite their clinical and social deterioration, however, they continued to work for and self-administer increasingly larger doses of the drug," the Massachusetts psychiatrist observes.

To elucidate the mechanisms at play, he and his associates attempted to measure changes in mood at the time of peak drug effect, 30 minutes after each injection. Using the Osgood Semantic Differential Scale, they were able to detect significant alternations in mood immediately following heroin injection. Subjects felt more carefree, relaxed, calm, elated, clear, and "stoned". Moreover, these effects persisted throughout the period of heroin addiction.

"Interestingly, those who 'shot up' more frequently experienced more elation and tension relief from the heroin than those who opted for longer intervals between doses and who correspondingly administered more heroin per injection," Dr Mirin observed. "Preliminary analysis of this data further indicates that frequency of administration is postively correlated with the mean plasma morphine concentration."

Six of the 14 patients chose to continue in a second phase of the study, in which they were treated with a narcotic antagonist before being given access to heroin. These men showed less psychopathology than they had during the unblocked phase of the study.

"Contrary to our expectations, the presumed frustration inherent in self-administering heroin and not getting 'high' did not uniformly result in subjects becoming depressed or hostile," Dr Mirin says.

"In fact, one subject experienced his unsuccessful challenge of the antagonist as an extremely positive event."

Methadone hinders driving — slightly

HOW DOES methadone affect driving ability? A Texas study compared the driving records of 174 methadone users, mostly male and nearly all Mexican-American, before drug use, while on heroin, and then during methadone maintenance.

In all categories—speeding, negligent collision, other moving violations, driving without a licence, and accidents—a similar pattern emerged, Dr James F. Maddux reported.

Pre-drug rates were moderately high (in what had been a predominantly teen-aged population).

Intriguingly, when these people began using heroin, their driving records improved notably—even though they claimed to have chalked up more miles in that period, looking for drugs or the where-withal to procure them. Once patients switched to methadone, their driving violations rose to, and often surpassed, the pre-drug levels.

Compared to all Texas drivers, (they were not compared with demographically matched controls) the records of the methadone users were "somewhat worse—but not much worse," said Dr Maddux, of the University of Texas Health Science Center and Southwest Research Institute, San Antonio. "We do not advocate any restriction of their driving privilege."

The dip in violations during heroin use, Dr Maddux suggested, may indicate the addict drives with extra care so his drug-seeking won't be interrupted by the police.

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Lesson in politics

NOT LONG AGO, federal government in the United States was being chastized for doing "too much" in the field of drug abuse treatment programming, for having too high a profile, for being too involved in the mechanics of programs, and for exerting too many controls.

Now, with the feds pulling in their horns, hiding their checkbooks, and shifting more and more treatment and training responsibilities over to the states, they are being accused of doing too little. (See backgrounder on facing page).

Seems they just can't win.

In the last half decade, however, the challenge of keeping up with the cost of groceries seems to have realigned individual. social priorities.

There are just too many other things to worry about, and however cynical one may become about the political process, one can't deny the astuteness of the politician in sensing what concerns his constituents most acutely.

Obviously, it is not drugs.

What makes matters worse, so far as program people looking for money are concerned, is that the private sector is even more vulnerable to shifting social priorities, thus infinitely more unreliable in terms of supporting long term goals.

In the United States, the Drug Abuse Council has been forced by its philanthropic foundation supporters to cut back activities, thus reduce its efficacy as a monitor of national trends, as a kind of non-partisan voice of the common man.

In Canada, the Council On Drug Abuse, established with great fanfare several years ago, has found its business and industry sponsors more and more tight-fisted. Consequently, CODA's efforts in public drug education remain somewhat uncertain.

The lesson to be drawn from this current state of economic sparseness is that despite all the good intentions and zeal of groups within the private sector, unless government takes on the bulk of work in planning and implementing drug abuse treatment, research, and education, it just won't get done. Despite all the sniping from the sidelines, government is the only social institution large and wealthy enough to maintain a stability in this critical field of public health.

The current state of depression and uncertainty in the field of drug abuse is clear evidence of the need for objective, unpartisan institutions, within government, that will maintain some consistency of effort, and keep reminding politicians that phenomena such as drug abuse will never be wiped out by a succession of futile "wars".

Sure there is a need for effort in the private sector, but as an adjunct too, and not a replacement for, rational, long term, consistent initiatives by apolitical institutions whose permanence is underwritten by government, and whose advice is usually heeded.

And isn't that what the public is paying for anyway?

A victim of success

AS RECENTLY as five years ago, federal efforts to combat increasing alcohol problems in the United States were plodding along with a miserly $17 million a year.

Today, the agency with this prime responsibility, the National Institute on Alcohol Use and Alcoholism (NIAAA), is charging forward atop the steam of the $150 million allocated for fiscal '75.

At a time when the field of alcoholism is coming of age, it is somewhat disconcerting to learn that Dr. Morris Chafetz, the man who shepherded the federal alcoholism effort from a unit within the National Institute of Mental Health into an institute in its own right, is calling it quits.

Granted, Dr. Chafetz promised his wife he would throw in the governmental towel after five years in office. It's comforting to know promises of this kind are kept occasionally.

At the same time, one can't help but speculate as to other reasons that undoubtedly contributed to Dr. Chafetz's decision.

A dynamic, highly visible and often outspoken leader of the rumor-riddled NIAAA, Dr. Chafetz undoubtedly stepped on many a bureaucratic toe during his turbulent tenure.

Quite apart from the routine Washington in-fighting, it is certainly no secret Dr. Chafetz lost many friends after publication of the US Alcohol and Health Report which concluded that moderate drinking had some benefits.

So far as Dr. Chafetz is concerned, he may well believe he is a victim of his own success.

In an interview with **The Journal** a few weeks ago, he in effect wrote his own epitaph. The message was clear.

"You could interview me in 10 years time and I will find that the route we went was wrong. I am not going to feel guilty. I am operating, as all of us are, with the knowledge I have at that point in time, trying to do the best I can."

He said never in his fondest dreams, having been in the field for so long, did he think the NIAAA would accomplish so much, so fast.

His final statement at that time: "We can get killed by success and I am very concerned about that issue."

Letters to the Editor

AWAREness

Sir:

I have just finished reading your excellent article about the Aware program in **The Journal** (May 1) and would like to commend you for your fair and objective reporting of a program of which we are justifiably proud.

Having been in the field now for over a year we have been most pleased to discover that there has been a high level of receptivity from the Saskatchewan community to the Aware approach. It is on this basis that we will formulate future directions in the program, and for this reason it is especially heartening for us to have our approach reinforced by a publication with the credibility of **The Journal**.

As you indicated in your article, we have already shared some of our insights with Manitoba on a cost-sharing basis and would suggest to any other interested jurisdiction that we would be delighted to make our materials available on a similar basis in order to avoid costly duplications.

Once again let me express our appreciation for your fine work.

Walter E. Smishek
Minister of Public Health
Saskatchewan

ARF position?

Sir:

As a former user of cannabis who has just barely managed to return to society (after two psychotic breakdowns, amongst other disconcerting experiences) I am dismayed by the stance taken by ARF. Your position used to be clear and was a source of comfort. Now, what is it—"No, Yes, Maybe, Personal Choice, Let Us Weigh The Costs"? You are, I believe, inching your way towards acceptance.

When I testified to the Senate Committee as regards Bill S-19 I suggested that your views be considered in the light of what we know about the Le Dain Commission—namely, that the ability of the commissioners to reason had been diluted by a rather enthusiastic conception of the role of participant observer.

Andre McNicoll
Ottawa

Daytop staffing

Sir:

I am writing to express my thanks for the space afforded my talk at a recent Addiction Research Foundation Seminar (**The Journal**, June 1).

By and large, the article was a fair representation of my talk. However, I am somewhat chagrined by the quote which was printed out of context and which has triggered off a series of phone calls from colleagues. To wit, "Devlin said use of ex-addicts in treatment programs, particularly at Daytop, has been declining. *And that's the way I want it.*"

The last line specifically referred to a section in my paper which dealt with the increasing number of Daytop graduates who are finding employment outside, and the fact it is my belief that the outside experience gained would certainly make someone a better staff member were he to choose to return.

Daytop Village is committed to a marriage between professional and para-professional expertise towards the common goal of treatment.

It is, moreover, an organization dedicated to the proposition that the words "ex-addict" and "professional" are not separate entities as witnessed by the increasing number of Daytop ex-addict staff who have earned degrees, and who undoubtedly epitomize the word "professional" in its finest sense.

Charles J. Devlin
Administrator
Daytop Village
New York, N.Y.

THE JOURNAL welcomes letters to the editor for publication. Letters, which must be signed and kept as concise as possible, should be addressed to The Editor, The Journal, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto M5S 2S1, Ontario.

"Sorry Ma'am—no pot . . ."

Games fo

IN HIS recently published book *Subliminal Seduction* journalism professor Wilson Bryan Key advances the rather novel thesis that alcohol advertisers, by means of photo-retouching, introduce into their ads hidden symbols that act on us at a subliminal level (i.e.—we do not consciously perceive the hidden images) to influence us to buy the products.

Dr Key finds hidden in the ice cubes of alcoholic beverage ads, for instance, all manner of strange, bizarre, perverse, obscene, and mythical symbols which, he asserts, unconsciously stimulate us to purchase because the subliminal images tickle our sexual fantasies, (in the ice cube of one such advertisement. Dr Key sees a polar bear copulating with a nude woman; in others he spots representations of human genitalia in various stages of approximation; in a television beer commercial he sees a pantomime of fellatio); our death wishes, (Dr Key sees skulls or death masks in the ice cubes of drink ads); and our collective unconscious. (in one Calvert Whisky ad showing a glass containing whisky and four ice cubes, Dr Key sees ancient fertility symbols (a volcano), phallic symbols (two fish), and a bewildering variety of symbols for danger, death, and evil (the head of a rat, a mouse, a lizard, scorpions, three wolf heads, a shark, a dead bird, and a grinning cat)). In short, Dr Key's theory is for the Jung at heart.

Backgrounder

After a hectic 5-year history, the President's Special Action Office for Drug Abuse Prevention is no more. SAODAP went out with style . . . Milan Korcok, The Journal's Contributing Editor, was there

WASHINGTON—Was it a wake or wasn't it?

One of the guest speakers called it a memorial service.

Others were ready to vault the trenches and "continue the fight" . . . "carry on the battle".

SAODAP was winding up, and instead of sneaking out the back door of their compound near the White House and into new offices of NIDA—up the road in pastoral Maryland—Dr. Robert DuPont, Peter Joshua Hammond, and the communicators of the special action office were taking the high road—going out in what one of their most consistent critics had to admit was "style, real style".

What did he mean by style?

Style was a four-hour, multi-media "service" that pitched 150 of the drug abuse industry's invited elite through a happening that was sometimes frenetic, other times contemplative, but always controlled.

At the first sign of audience nod, "click" goes a button and "flash" comes film-clipped Bill Cosby with "Captainnn Junkieee".

When reporters questions become too solemn (reporters always take themselves too seriously), click goes the button and an audiotaped George Carlin invades the room: "We'll give you the orange pills now kiddies, the other colors when you grow up."

When the platitudes become too precious, the gallows humor of the enforcement films (A River of Death . . . Called DRUGS) is sure to break up the house.

The production was heavily staged, there were speakers, there were film and audio flashbacks to the images of the 60s, there were the inevitable reflections on "How we got here".

As expected, there were ubiquitous reminders of SAODAP's achievements—particularly treatment emphasis, and the elevated political priorities for drug efforts. There were also commercials for the office's media efforts: the brand new language, the materials moratorium, publications still on the press.

In all respects it was the last hurrah. The only thing missing was an 11th hour plea from the President to stop the wake and revive the corpse. It never came.

But beneath the staging, and the PR, was the hidden agenda: "Where do we go from here?"

Despite Hammond's attempts to characterize the end of SAODAP as the "Beginning" of the new drug abuse challenge, (a variation on the "turning problems into opportunities" cliche), there was a clear sense of finiteness about national drug abuse efforts.

With the federal initiatives in drug abuse plumeting from near-cabinet status into the bowels of HEW, and the feds playing scrooge and throwing a lot of responsibility over to the states and the private sector, the elite was worried.

"Where do we go from here?" was a question on everybody's mind. It was a sobering reflection on the major concern of thousands of individuals and institutions finding themselves with endemic and growing narcotic use on the streets, and polydrug abuse that only now is starting to show its real shape and size.

Peter Bourne, former deputy director of SAODAP and now consultant to the Drug Abuse Council, stressed that the need for treatment facilities—to which SAODAP had given so much emphasis—was as great today as it was two years ago, when politicians were clammering about the corner on heroin abuse having been turned.

"In many parts of the country we again have waiting lists", said Bourne. "We need to spend more money and demand more support to ensure that treatment is expanded."

Certainly, he said, treatment ought to keep pace with the bounding emphasis now being placed on more and better law enforcement.

Dr. Daniel X. Freedman, chairman of psychiatry at the University of Chicago, gently, though precisely, castigated federal government for "breaking away" from its responsibility in manpower training, a responsibility that just cannot adequately be taken over by the states.

"There is no way out of the fact that this training is a federal responsibility." If this responsibility is not met, "we are going to be in trouble."

Yet in most cases the criticisms were made without much acrimony. The problem was not exclusively that SAODAP was winding up, but that the whole drug abuse effort was no longer as high a social priority as in those days when the world "epidemic" was part of every politician's vocabulary.

Dr. Thomas Bryant, President of the Drug Abuse Council, put it most cogently in his semi-eulogy.

"We have one major flaw in this field . . . we have not explained to the public what we are all about.

"For those of us who remain in the field, the major task for the next few years will be to explain in a responsible fashion what we are about, what we can accomplish, and what we cannot accomplish. It will not do to announce new epidemics without explaining what that means and what can be done about it."

Bryant's warnings were made even more ominous by the fact that the private sector (especially major foundations) is retreating faster than anybody.

"The foundations are getting out of the field," said Bryant. And he should know as the DAC, which is funded by a consortium of four foundations, has sharply cut back its own activities.

Though the Council has extended its original five year mandate by two or three years, it will be operating at a greatly reduced budgetary level, and it will be terminating its fellowship program as of this year.

"I think that (kind of retreat) is deplorable, because the private sector has a particularly critical role to play," said Bryant.

"What this means is that those of you who are affiliated with the federal government are going to find yourselves more and more alone. I feel compassion for those of you who are going to stay in this field."

The growth of the national drug response during the past decade, particularly the last half of that decade, was really quite dramatic. Some say it was too far too fast, too crisis-oriented, too responsive to the symptoms of abuse such as crime and urban instability, and too little concerned with abuse as a signal of deeper social malady.

The first director of SAODAP, Dr. Jerome Jaffe, admits: "We tried to do too much too quickly."

But there was a reason for that haste, he says.

"Some of us had the premonition that presidential interest might not last very much longer than the upcoming election. It seemed to us that if there were more things that needed to be done, we had best do it, even though that may have been more costly than developing a carefully planned, deliberate strategy."

But just because there was haste, does not mean the half-decade's activity was a total waste. As some of the participants at the "wake" emphasized, there was a lot to show for all that money, effort, and agony.

Governor Raymond P. Schafer, chairman of the marihuana commission, sees positive value in the lowering of tensions and emotions. "We now find people willing to talk about and discuss drug use. We find parents talking to children about it openly."

Allan Cohen, director of drug abuse studies at John F. Kennedy University, and author of Understanding Drug Abuse, values the process that has evolved: "If it has helped us to learn to help people and respond to problems . . . if we can use the data we have acquired and not be afraid of our failures, then we have done a lot."

Daniel Freedman in summation: "The number of people and institutions willing to deploy funds has grown enormously . . . knowledge has been shared. A great deal has happened both in terms of what we have learned and in the populations engaged. From that perspective, we have come a long, long way."

for the Jung at heart

By Wayne Howell

Now, since I have a moderately inventive mind (I say "moderately" because I must confess that prior to reading Dr Key's book it had not occurred to me that polar bears might be copulating with humans in liquor-ad ice cubes) and a natural curiosity, I decided to do some symbol spotting a la Key. I chose as my subject the liquor ads in the June 9th issue of Time magazine.

First up was the ad for Ron Cabana Dark Rum on the flip-side of the front cover. I bombed. Not a phallic symbol to be found. On to page 44 where I fared no better with the Haig Scotch Whisky ad. I tried blocking out all non-perverse thoughts but still no symbols came. Nothing. I began to get a sinking feeling, the kind you get when you know you are flunking your Rorshach test. But I persevered and pushed on to the Bolshoi Vodka ad on page 49.

Breakthrough! Even though the cunning ad-men had smeared the side of the half empty glass with little rivulets of Bloody Mary to throw me off the trail, I spotted the Death's Head (or was it the head of a hydrocephalic child?) staring out at me from the single ice cube.

Eureka! Encouraged by the breakthrough, I commenced to make a diligent search for genitalia, for camels cohabiting with Croatians, for roosters raping rectangles . . . but again my imagination failed.

Or was the House of Seagram just too devious—was my unconscious mind soaking up the subliminal images all the while? Images that would stimulate an inchoate yearning for Bolshoi and tomato juice. Bolshoi and orange juice? Should I perhaps knock back a few and try again when my conscious mind would be more 'flexible'?

In the interests of scientific objectivity I deferred and pressed on to the Teacher's Scotch ad on page 53. A Snap. I got the message immediately but there was little satisfaction in that since the message wasn't even subliminal—just good old fashioned hard-sell sex, with a comely young wench in academic cap and gown telling me to 'pick up a teacher' as she proffered me the bottle. Rather disappointing—when you're into this subliminal thing and just getting good at it, you want a bit of a challenge.

On to page 69 and the Gilbey's Black Velvet Whisky ad. I immediately spotted the sublimal significance of 'the long phallic, cylindrical shape of the black container standing close against the female, open, elliptical-rimmed vaginal symbol of the glass' but could take little credit for the discovery since the advertisement was one of the examples used in professor Key's book.

And so I pressed on to the last liquor ad in the issue—the Wiser's De Luxe Whisky ad on the back cover. Two glasses, two ice cubes—my last chance. It was easy. Only a simpleton could have missed the crouching white dog in the right-hand ice cube (subliminal dogs, according to Dr Key 'appear to provide an unconscious stimulus for the purchase of alcohol'). And in the left-hand ice cube in a semi-supine position a dog—a terrier I would guess by the shape of the ears—leans back while an amphibian creature, a frog in fact, appears to be making a dive for the dog's groin.

It's very easy once you get the hang of it. The only problem is that once you have learned to see subliminal images in ice cubes you start to see them everywhere—in the wood grain of your desk, in dead leaves on the lawn, in all manner of signs and symbols. As a matter of fact, I'm not so sure about the logo of **The Journal** anymore—that little hand holding up what looks like a tree of some sort. Hold it up to the light. Look at it sideways, upside down. Don't let 'em fool you . . . .

(Wayne Howell is an Ottawa physician and freelance writer.)

Crouching dog peers out of ice cube!!!

Traffic accidents

Alcohol fixation 'misleading'

REAL PROGRESS in preventing fatal traffic accidents will come only after the problems of alcohol involvement are more clearly defined.

At that point countermeasures can be specifically applied, says Richard Zylman, associate research professor, Center for Alcohol Studies, Rutgers University.

The whole question of blood alcohol concentrations in drivers involved in crashes had been disjointed and often inaccurate, he said here.

He has made a recent review of the literature which showed that the term "alcohol involvement" assumed that an impairing amount of alcohol, such as a 0.10% blood alcohol concentration, was related to the crash.

In fact, "such statements were based on research studies and medical examiners' reports that presented incomplete information and were highly biased," he said.

No more than 36% of fatalities involved alcohol at 0.10% and more as a causal factor.

"Eventually, when more sophisticated and objective information becomes available that proportion that involves alcohol in some causal fashion may be something in the order of 25% to 35%".

The percentage of accidents related to alcohol is important, he said.

"If it is only 30% it means there must be other major factors causing deaths on the highway . . . factors to which we are paying very little attention as long as we are making alcohol the prime, and virtually only, crash-related factor for attention.

"In this sense, over emphasis on alcohol may be costing lives."

Because a driver is killed and has a blood alcohol concentration of 0.03% or 0.07%, "does not necessarily mean that he was also responsible for the crash nor that alcohol was the cause, any more than that sobriety indicates innocence."

Presence of low blood alcohol concentration is only one factor among many that should be considered.

Mr. Zylman said if alcohol involvement included principally blood alcohol concentrations beyond 0.10% "then you will not only have whittled the problem down to something more manageable but will have opened the door for consideration of the causes of the other 70% or so of all fatal crashes, about which we seem to show so little concern."

Alcoholics 15 years later

A 15-YEAR followup study of 30 patients at an alcoholism treatment clinic shows six have alcohol brain damage, six are abstainers and seven drink without gross problems.

The remaining 11 are either heavy or binge drinkers, Merton Hyman, of the Center for Alcohol Studies, Rutgers University, reported here.

The study set out to find the fate of 54 men who attended the clinic at Roosevelt Hospital, Metuchen, N.J.

Six men could not be found, four refused to be interviewed, 18 were dead—10 with causes commonly associated with alcoholism—and one died after interview.

Mr. Hyman said that of the remaining 30 men, one has been in a mental hospital for many years with alcohol brain damage, four others seem grossly deteriorated, mentally and physically, and one is a borderline case.

Nine men are heavy drinkers and over the past three years have either been in hospital or lost their jobs because of alcohol. Two other men have changed from heavy to occasional binge drinking.

Five men have sharply reduced their daily alcohol intake and have no gross problems and another two have reduced both the quantity and frequency of drinking.

Six men are abstainers and two of them are active in Alcoholics Anonymous.

Mr. Hyman said that as only one man with gross deterioration was in an institution, "there are probably many more brain damaged alcoholics in the community than there are in mental hospitals.

"There was much less social deterioration among the men with continuing drinking problems than would be expected either from the theory that alcoholism is a progressive disease or from popular stereotypes of alcoholics.

"This undoubtedly resulted from the high degree of support, both social and financial, that the men received from their families and it was primary or secondary help from them that enabled four of the five grossly deteriorated men to avoid long range institutionalization".

Mr. Hyman said several factors distinguished the abstainers from the daily drinkers. At the time of clinic attendance 15 years before, five of the abstainers had serious legal problems and four did not have steady employment. None of the daily drinkers faced these problems then.

It would seem that at clinic intake, alcoholics with less going for them are even more likely to improve so far as drinking is concerned—if they live long enough, he said.

Teenage alcohol use may have peaked

RATES OF alcohol usage among some groups of high school students in San Mateo County, California, may after seven years be levelling off or even dropping.

Ms. Lilian St Clair Blackford, biostatistician who has since 1968 run the yearly drug surveys, said new data is now being analyzed and is "a real cliff hanger". Rates in some groups showed a small drop between 1973-74.

She warned here, in a review of the surveys, that "we made a bold prediction with the 1970 results that everything was going down, which proved that it is not safe to make a projection based upon two points.

"However, trends like this have appeared in some of the other drugs over the past two or three years, so there is hope that the top rates of alcohol use might be reached soon. After all, they can't go over 100%".

Ms. Blackford said that in 1969-74 use of alcohol on 10 or more occasions among seventh grade boys had risen from 10.9% to 24.9% while for girls it had increased from 8.2% to 19.7%.

For senior boys the increase was from 41.6% to 66.4% between 1968 and 1974 and for girls from 27% to 59%.

In those reporting use of alcoholic beverages on 50 or more occasions in the preceding year, the rate for senior boys increased from 27% in 1970 to 44.8% in 1974 and over the same period consumption for girls rose from 13.5% to 30.6%.

Ms. Blackford said to date the surveys "provide no evidence that would say that either using alcoholic beverages or smoking marijuana leads to the use of other drugs.

"However, it can be said that persons who are potential multiple drug users find that alcohol is the easiest one to procure and that it can also be used to augment other more expensive drugs".

Ms. Blackford said she has found over the years that "kids are amazingly truthful and frank.

"If you could see the returned survey forms with their thoughtful and pithy comment you would understand why the staff and volunteers who have edited forms change from scepticism to confidence regarding the survey results. By now I have been exposed to over a quarter of a million survey forms and each year my confidence increases".

Russians see alcohol differently

MODERN RUSSIAN attitudes towards alcohol and heavy drinking show striking differences from attitudes in Western society, research by Soviet-born Dr. Boris Segal, Harvard University, reveals.

His investigations involved data on 1,703 alcoholics who attended hospitals and outpatient clinics in a number of Russian cities including Moscow and were described here. Dr. Segal is with the Russian Research Center at Harvard.

He said among alcoholics the violations of social, economic and working conditions were four times higher than among non-alcoholics and their divorce rate was three times higher. Yet there was no difference between the two groups in social, economic and educational backgrounds.

In 70% of the cases he studied, the parents accepted moderate drunkenness, and in 10%, parents tolerated even hard drinking.

Among friends of alcoholics, some 53% were heavy drinkers and another 43% were rated moderate drinkers. Influence by friends was greatest in the teenage population.

Dr. Segal said that before the revolution, heavy drinking was limited to ritual occasions, except among the poor. But the revolution, Stalin's purges, World War Two, and economic stringency have produced tremendous psychological consequences in the society.

These include alienation, decrease of social communication, stress, decline of the family, loss of traditional Christian values coupled with a disappointment with Marxist ideological slogans, and a loss of moral taboos, particularly towards the abuse of alcohol by women and young people.

In a totalitarian society, individual choices are few. Thus drinking "as one of the forms of escapism, now affects all Soviet social groups among both the urban and rural population", Dr. Segal said.

Alcoholic criminals should have choice

CRIMINALS WITH drinking problems must be offered a choice of treatment goals on release if the majority of them are to be reached, according to Dr. David Goodrick, PhD, Wisconsin State Reformatory.

He said problem drinking seriously affects the success of parole completions in Wisconsin—only 60% in problem drinkers against 90% among those without a problem.

The program in Wisconsin is a six week voluntary educational one presented near the time of release. Those who take part are followed up after release by staff members, who also confer with the family and parole agent. Crisis intervention is provided if needed.

Dr. Goodrick said in his report here that many prisoners are intoxicated when they commit their crimes but they do not see themselves as alcoholics.

For a majority of these men "learning to drink in a more responsible manner is the only treatment goal which they are willing to accept and attempt to achieve".

It has been found that if a prisoner does drink irresponsibly on release he is more likely to reconsider abstinence if he thinks treatment personnel are sincere with him.

Dr. Goodrick said data is not yet available on the ratio of alcohol abusers and alcoholics who attempt to achieve responsible drinking or abstinence.

Physicians termed 'legal connection'

MOST AMERICAN physicians are unaware that all sedative drugs are potentially addictive and if a patient loses control of one he cannot successfully control the use of others.

"Thus the physicians become the inadvertent 'legal connections' for the sedative addict", said Dr. Lawrence Wharton of Long Beach General Hospital. Dr. Wharton is a former board member of the National Council on Alcoholism and past and present consultant to state agencies in Texas and California.

HARVEY McCONNELL

reports from

the annual forum

of the National Council

on Alcoholism,

Milwaukee, Wisconsin

Availability of alcohol, "mild" tranquillizers, barbiturates and bromides, means that "in our addictive society it is unfortunately not difficult for each person to find his own legal connection".

He said that among many fellow physicians "when a new drug which produces a more pleasant state of feeling in the user is developed we rush to share this wonderful new drug with the world and seem completely taken back when it is discovered to be addicting.

"Often we will even deny the fact of addiction in the face of overwhelming evidence and we fight restricting the use because it makes our patients feel so good and they want it so much".

Dr. Wharton cited two recent and personal examples of the "legal connection" at its best:

Two recovering alcoholic patients at his hospital went to other hospitals for examinations—one for a pension and the other for post-operative eye surgery—and were away several days.

One patient returned with 100 chlordiazepoxide tablets and the other with 100 diazepam tablets.

In neither case had the patient asked for the drugs.

Dr. Wharton said he knows a doctor who discovered recently the addictive potential of diazepam and stopped taking it. It took six weeks, four of them in hospital, for him to get over the acute withdrawal symptoms and another six months before he could function properly.

The obvious question is: Why did the doctor take the drug knowing what might happen? "The equally obvious answers is that *the doctor didn't know*", he added.

Passive victims attract drunken deviants

AT LEAST half the 220 child molesters studied in prison by Dr. Richard Rada, New Mexico school of medicine, said they were drunk when they committed the sex crimes.

And at least one-third of them are alcoholics, Dr. Rada said here.

Molesting children is one of the many indices of their social maladjustment, which is secondary to the effect of long-term alcoholism, he said.

"As their alcoholism removes them further and further from acceptable and potential adult sexual objects, the willing or at least passive, early pubescent victim becomes an attractive sexual outlet", he said.

These men need ongoing treatment after release from prison for both their sexual deviance and alcohol addiction.

Tranquil and sober

A GROUP of chronic alcoholic outpatients given chlordiazepoxide not only have not abused the drug but many have stopped taking the tranquillizer and remained abstinent.

Dr. Emil Rubenstein said the 105 patients who have been studied over the past 18 months at the Veterans Administration Hospital, Brockton, Mass, tend to take the drug as prescribed. There was almost no evidence of any abuse, he said here.

Drug research

'Transitional intervention' model developed in UK

LONDON—Researchers from the Institute for the Study of Drug Dependence have completed a model of what they describe as "transitional intervention" as an approach to dealing with drug abuse.

Nicholas Dorn and Anne Thompson studied a sample of over 3,000 English schoolchildren from 29 State secondary schools (aged 14 and 15) in an attempt to identify the "social process of becoming an experimenter".

Emphasizing that they were looking for this social process rather than asking how experimenters are different from the rest, they suggest that it has four identifiable stages:

"No contact": Not knowing a drug user;
"Contact": Knowing a drug user;
"Offered": Being offered a drug;
"Accepted": Accepting one offer, not necessarily any subsequent offer(s).

The study found that the proportions of pupils at the various stages differed considerably according to school attended. Each step in the process (no contact—contact—offered—accepted) did not guarantee the taking of the following step i.e. coming to know a drug taker did not guarantee that a pupil would be offered a drug; nor was being offered a drug a guarantee that it would be accepted.

The findings suggested that pupils at the "contact" stage were most likely to be urban middle-class children, cigarette smokers, older than the rest of their schoolmates, and female.

Yet pupils who reached the "offered" stage were equally distributed between the sexes.

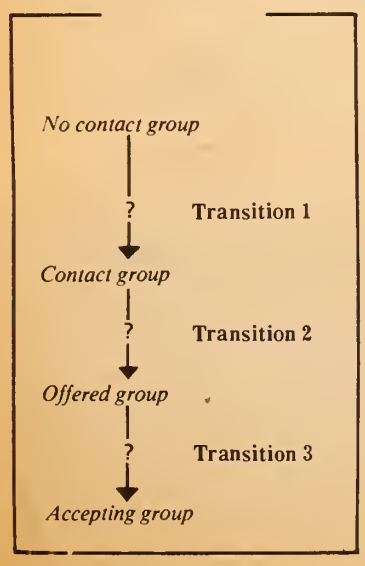
"So factors which predispose one to knowing a drug taker do not necessarily further predispose one to receiving an offer of a drug," the report says.

The authors go on to argue that it is "a gross oversimplification to compare and contrast drug takers with 'the rest' as individual non-users may be non-users for very different reasons."

"One must distinguish between pupils who have not taken a drug because they have rejected an offer, those who have not had any offers to reject or accept (in spite of knowing someone who could offer them a drug) and those who do not know any one who might offer them a drug."

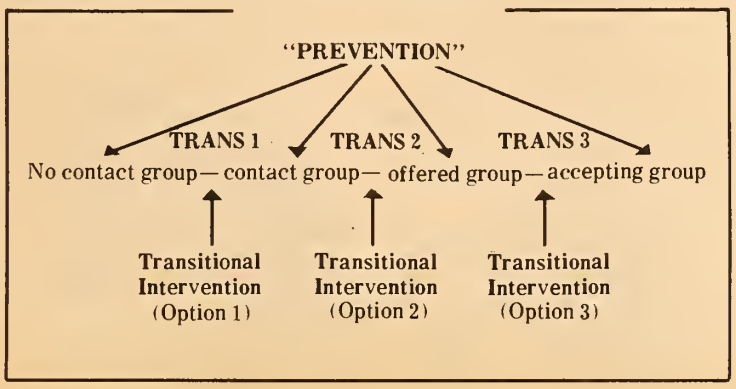
By raising the question of the nature of the transitional processes between the no contact, contact, offered and accepted stages, the study focussed away from "What sort of people use drugs?" to "How does it happen?" (particularly in relation to each transition.)

The report concentrates on three main transitional stages (although accepting that there are others which may result in a whole "tree" of options). The model is:



The authors argue that present social policy in the UK is guided by the general notion of "prevention" although previous research has demonstrated the inadequacy of "this abstract and ill-defined concept in the field of drug education." They claim that the study suggests that "prevention" may also be too woolly a concept to be successful in wider areas than school education.

What should be studied is "the career" of the experimenter, they say. Prevention efforts could then concentrate on "focused intervention" involving the actual transitional process. The basic difference between " prevention" and "transitional intervention" is illustrated thus:



"It is theoretically possible to intervene in any of the transitional processes that together make up the 'career' routes of experimenters, casualties, those who give up, and others. The type of intervention depends on the transitional process in which one chooses to intervene."

The authors conclude: "This is not to recommend any particular intervention but to put forward the concepts of transitional processes and of intervention into these processes as an aid to formulation, implementation and evaluation of policy options."

Mr Dorn told **The Journal** that the study had been favourably received by Government officials at the Department of Health and Social Security.

Germany tightens drug legislation

BONN—Although the rate of narcotics smuggling and peddling decreased last year, West Germany plans to enact tighter laws with higher penalties to fight the drug problem.

A bill calling for sentences of up to life imprisonment for drug-related deaths was introduced recently in the Bundesrat, the upper house of the West German parliament, and is now in committee.

The bill forsees minimum terms of 10 years, maximum life, for narcotics smugglers and dealers proven responsible for "widespread addiction" and drug-related fatalities.

Peddlers and smugglers linked to "organized rings" or responsible for "distribution of large quantities of narcotics" would, in the future, face a minimum of three years' imprisonment.

The measure would also empower law enforcement agencies to use wire-tapping and electronic surveillance techniques in cases where large-scale, professional drug selling and smuggling is suspected.

Diether Posser, justice minister of Northrhine-Westphalia, West Germany's largest state, is the author of the bill.

Introducing it in the Bundesrat recently, he explained that although narcotics consumption had leveled off during the past two years, the amount of hard drugs entering the Federal Republic had increased.

Moreover, he said, the number of drug-related deaths had risen sharply.

Increasingly, he said, the narcotics trade has been concentrated "in the hands of unscrupulous, tightly organized and highly disciplined professional gangs".

While the number of dealers has diminished, those active are "tougher and more dangerous than ever".

Posser sees his proposed measure as a "pre-emptive one, especially in view of the resumption of poppy growing in Turkey".

Concurrently, the West German federal ministry of interior disclosed a 0.4% decrease of drug-related arrests and convictions last year as compared to 1973.

During the previous 12 months period there had been a 5.2% increase.

The ministry registered 26,909 "drug crimes" in 1974, a figure that includes usage and addiction as well as dealing and peddling.

The heaviest traffic in opium derivatives continues to be via the West German-Dutch border, where narcotics and customs agents last year arrested 2,166 smugglers (compared to 1,152 in 1973).

The principal traffic in hashish and cannabis, however, is still the German border with Austria, which serves as a funnel for shipments from the Middle East via Eastern Europe and the Balkans, especially Yugoslavia.

Liver ailments increase in Germany

DUSSELDORF — Alcohol-related liver ailments are increasing "sharply and dangerously" in West Germany, according to the Northrhine-Westphalian state anti-addiction agency.

The state government agency estimates there are two million people in the country—about 3% of the total population—suffering from acute and chronic liver diseases.

Rapidly rising alcohol consumption is considered a primary cause.

During the past 20 years, according to the agency, alcohol consumption has increased three-fold in the Federal Republic and is now at 14 liters of pure alcohol per capita annually.

Around the world

STIFFER PENALTIES

The Dutch government has proposed stiffer penalties and more police action against dealers in hard drugs, especially heroin, under increased international pressure to crack down on drug traffic through the Netherlands. Under the proposal, domestic traffic in hard drugs would carry a maximum eight-year prison term and international traffic, a 12-year term.

DUTCH DRINK

The Dutch drank 160 pints of beer, 22 pints of wine and 5.8 pints of spirit per head of population last year, according to Central Statistics Office, The Hague. The figures showed a 116% rise in beer consumption, a 260% rise in wine consumption, and an 86% rise in spirits consumption since 1964.

TOBACCO CROP

World tobacco output in 1974 was estimated at a little more than the 10.4 billion pounds produced in 1973. US harvest was up 13%, according to United Nations figures.

SMOKELESS ZONE?

Sweden plans to raise a nation of non-smokers and will begin with children born this year. The program is expected to include intensive antismoking education in maternity clinics and schools, pregressive restrictions on cigarette advertising, regular price increases through higher taxation (cigarettes already cost about $1.50 a pack in Sweden), prohibitions on smoking in public places, and greater efforts to help people quit.

NORWAY STRIKES

Norway has now banned all advertising of tobacco products, requires health warning statements on all packages, prohibits sale of tobacco products to people under 16 years, and permits the government to regulate content, weight, filters, and other health-related characteristics of tobacco-products.

New US rules on confidentiality

By JOSEPH GRIMM

DETROIT—Within a few months, United States alcohol and drug abuse programs will be able to afford their patients more confidentiality than ever before.

The Department of Health, Education and Welfare, in conjunction with The Special Action Office for Drug Abuse Prevention, has proposed a new ruling concerning the confidentiality of alcohol and drug abuse patient records.

The 21-page proposed amendment is "written to be clear, not to be confusing," according to Grasty Crews II, general counsel of SAODAP.

Operations covered under the amendment will be all drug and alcohol abuse prevention functions conducted, regulated or financially assisted directly or indirectly by any department or office of the federal government.

The statute defines confidential information as records of patients' identities, diagnoses, prognoses and treatment.

Confidential information includes any information on the patient, recorded or not, received or acquired in connection with the program. It includes information on patient progress, attendance and whereabouts.

The statute places definite limits on which information can be released, to whom, for what purposes, under what circumstances, and for how long, thus giving the patient substantial control over who has access to his or her files.

Signed releases, when required, must contain the names of the program making the disclosure and of the patient and the recipient as well as the reasons for the disclosure. They must be dated and include a statement that consent is subject to revocation at any time. Unless an earlier date is specified by the patient, all such disclosures expire 60 days after being made.

Recipients of the information are prohibited from redisclosing the information without further written consent from the patient.

Generally, people seeking confidential information about drug and alcohol abuse program patients are referred back to the original source of the data.

Special situations permit disclosure without the patient's consent. These situations are also strictly defined by the statute. The two main cases in this area are medical emergencies and audits.

Audits, research, and program evaluations may be allowed access to patient records with special stipulations. One prime stipulation is that patient-identifying information is generally not released.

A second stipulation is that only specifically needed portions of records are released.

Penalties for violating confidentiality under this statute are up to $500 for a first offence. Each subsequent offence could cost the violator as much as $5,000.

The statute writers say they tried to consider two streams of legal thought and social policy.

"One has to do with enhancing the quality and attractiveness of treatment systems. The other is concerned with the interest of patients as citizens, most particularly in regard to protecting their rights as citizens."

Use of undercover agents and informants in treatment programs is forbidden in the statute, except when the program director is suspected of being involved in a crime or should, through "an exercise of reasonable care," know the crime is being committed. In these cases, the use of special agents and informants is closely regulated.

People under 18 years of age or the state's age of majority need a parent or guardian's co-signature to release information about themselves.

In programs where minors are admitted without adult consent, the minors alone are responsible for their confidential profiles. Provided the minor is capable of rational consent, financial inquiries, bills and notes of application cannot be sent to anyone without the minor's express, written consent.

Intra-agency communications are permitted as are communications with certain central registries to ensure against multiple enrolment by a single patient.

Patients committing or threatening to commit crimes on program premises or against program personnel may be reported to police without violating confidentiality. The police are not, however, to be told that the suspect is a patient.

The complete text of the statute is contained in the Federal Register, Volume 40, Number 91, Part 4.

Study suggests

Pot harmful to heart disease patients

By THOMAS HILL

HOUSTON—The smoking of marijuana probably has no adverse effects on heart function in normal people, according to a recent study from the University of Illinois, in Chicago.

The study was reported here at the annual scientific session of the American College of Cardiology.

It would, however, definitely be harmful to people with coronary artery disease, said Dr Charles Kanakis, Jr, a member of the Chicago team that has been looking into the drug's effects on heart performance.

Dr Kanakis, Dr Jean M. Pouget and Dr Kenneth M. Rosen carried out a series of experiments in 18 normal male volunteers between the ages of 22 and 30 years. They injected the subjects with Delta-9 tetrahydrocannabinol (Delta-9THC) obtained from the National Institute of Drug Abuse, Center for Drug Study.

Delta-9THC is considered to be the ingredient in marijuana that is active in the body. Before it became available in pure form, pharmacologic studies in this area were difficult, said Dr Kanakis.

Now, standardized experiments are possible because the dosage of the pure compound may be measured precisely and the investigator can be sure of the amount actually received by subjects.

In these studies the dose of Delta-9THC was 25 ug/kg body weight which, according to Dr Kanakis "in an 88 kg person would be almost equivalent to smoking one marijuana cigarette containing 5 mg of Delta-9THC."

Subjects admitted to the study had to pass a physical examination demonstrating they had a normal cardiovascular system, normal electrocardiogram, normal chest X-ray and a negative history of cardiovascular disease. They also had to have a satisfactory score on a test that screens for psychotic potential, and their prior use of marijuana had to be less than one ounce per week.

Dr Kanakis and his co-workers recorded "systolic time intervals" and blood pressure of all subjects at 5, 18, 15, 38, 68, 98 and 128 minutes after administration of the drug.

They found the heart rate increased significantly, from an average of 62 beats per minute to 95. The systolic and diastolic blood pressures did not increase significantly.

They measured a number of parameters of left ventricular performance (the pumping action) from the electrocardiogram. Their principal findings here were prolongation of the left ventricular ejection time (LVET), which went from 488 to 432 milliseconds, and shortening of the pre-ejection

Dr. Kanakis

period (PEP), which decreased from 114 to 95 millisecs.

The shortening of the PEP, explained Dr Kanakis, suggests augmentation in left ventricular performance. The increase in LVET is still not fully understood and the Chicago researchers are studying this further.

"None of the effects we've shown are detrimental in a normal person," Dr Kanakis said. "However, it would not be justified to say they're beneficial."

Another experiment carried out was to inject a group of nine normal volunteers with propranolol before giving them Delta-9THC. Propranolol, a so-called "beta-adrenergic blocking agent," will cause (among other things) a decrease in heart rate and a modest lowering of blood pressure.

Although the effects of the Delta-9THC were smaller when subjects received propranolol first, they nevertheless persisted. Dr Kanakis is not sure why the propranolol did not block the effects of the Delta-9THC.

"Perhaps the amount of adrenalin produced by the marijuana was so much that it overrode the beta blockade," he suggested. "Or it may be a direct effect of some sort."

What makes the above question difficult to answer is that a more basic question is still unexplained: How does the marijuana (or Delta-9THC) produce its effects on the heart.

It may be that it is causing adrenalin to be released, or that it is acting as a vasodilator, dilating the peripheral blood vessels. It could be a combination of these.

In any event, Dr Kanakis has demonstrated that the drug has significant effects on the heart. Although he regards these effects as "not detrimental in a normal person," he stresses that in persons with coronary artery disease, the increase in heart rate, resulting in higher myocardial oxygen consumption, would definitely be detrimental.

Hospital emergencies

MILWAUKEE—Special emergency room problems must be overcome before an alcoholism program can be run successfully in a general hospital setting.

This is the experience of Dr. Brian Nagy and his team after more than a year of operating an alcoholism service of inpatient and outpatient treatment at St. Joseph's Hospital, Elmira, N.Y. They combine a 14-day hospital stay with clinic visits and supportive services.

Dr. Nagy said at the annual forum of the National Council on Alcoholism here the idea of admitting alcoholics to a general hospital and providing supportive services—rather than seeing how fast the patient could be dried out and the bed given to a "legitimate" patient—met with some initial resistance in both community and hospital.

Overcoming that resistance was not as difficult as solving the major problems in the emergency room. Staff there, who are not part of the program, "frequently do not see the good results of their work but rather the negative aspects of dealing with hostile and unappreciative individuals".

A great deal of work was needed before the emergency room operation ran smoothly, he added.

OPIUM PROPOSALS

In Vientiane, Laos, the Pathet Lao are reported to have proposed looser laws regulating cultivation and marketing of opium. According to The New York Times (June 9), the Pathet Lao began its campaign in the mountain areas of Laos where Meo tribesmen have cultivated opium for generations as a major cash crop.

New Books

By RON HALL

Marijuana Today

. . . George K. Russell

The Myrin Institute, Inc. for Adult Education, (521 Park Avenue, New York, NY 10021) 1975 references: 61p.: $1.00 (paperback)

In this publication intended for laymen, the author presents background information and provides a survey of scientific findings including the effects of marijuana on the psyche, brain, lungs, reproductive processes, genes and chromosomes.

Marijuana—Deceptive Weed

. . . by Gabriel G. Nahas

Raven Press (1140 Avenue of the Americas, New York, NY 10036) 1975 revised edition: references: index: 352p. (hard cover)

Originally published in 1973, this book draws together historical and current information on the botany, chemistry, toxicology, pharmacology, and social aspects of cannabis.

Introductory Health: A Vital Issue

. . . by John S. Sinacore and Angela C. Sinacore

Macmillan Publishing Company, Inc., (866 Third Avenue, New York, NY 10022) 1975 index: 429p. (paperback)

In one chapter, drug use and abuse is discussed in a social-health context. Costs and benefits of drugs as well as society's reaction to drug abuse problems are presented.

Research Issues Series

. . . Superintendent of Documents Government Printing Office Washington, DC 20402

Drugs and Employment ($1.80)
Drugs and Sex ($1.45)
Drugs and Attitude Change ($2.25)
Drugs and Family/Peer Influence ($2.10)
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Drug Themes in Fiction ($1.05)

This ten volume Research Issues Series, intended to stimulate further investigation, includes seven volumes of abstracts of research studies, one bibliography, and two original essays exploring the cultural impact of drugs on literature. **(paperbacks)**

Other Books Received:

Ganja in Jamaica: Rubin, Vera, and Comitas, Lambros. Mauton and Company, Publishers, The Hague, 1975, 205p., $9.95.

Legal Aspects of Drug Dependence: Bonnie, Richard J., and Sonnenreich, Michael R. CRC Press, Inc., Cleveland, 1975, 367p., $64.95.

Drug and Behavior: A Primer in Neuropsychopharmacology: Abel, Ernest L. John Wiley and Sons, Toronto, 1974, 229p., $14.65.

A Handbook on Drug and Alcohol Abuse: The Biomedical Aspects: Hofmann, Frederick G. Oxford University Press, Toronto, 1975, 329p.

LSD—A Total Study: Sankar, D. V. Siva. PJD Publications, Ltd., Westbury, 1975, 960p., $29.50.

Alcoholism: A Handbook: Drew, L. R. H., Moon, J. R.; and Buchanan, F. H. William Heinemann Medical Books, Ltd., London, 1974, 189p.

The Use of Marihuana: A Psychological and Physiological Inquiry: Mendelson, Jack H., Rossi, A. Michael, and Meyer, Roger E. (eds.), Plenum Press, New York, 1974, 202p., $17.20.

Drug Use: Epidemiological and Sociological Approaches: Josephson, Eric, and Carroll, Eleanor E. (eds.) John Wiley and Sons, Toronto, 1974, 381p.

Alcoholism: The Hidden Addiction: Hoff, Ebbe Curtis. The Seabury Press, New York, 1974, 170p., $9.25.

Cocaine Papers: Freud, Sigmund. Stonehill Publishing Co., New York, 1974, 416p., $12.95.

Drug training for PQ police

MONTREAL—It's going to be back to school for all 4,200 members of the Quebec Police Force to study anti-drug work. Planning began one year ago and eventually all will have attended the course at the QPF training headquarters at Nicolet, Que.

Anti-drug courses are being run at the Nicolet institute about every two months. They cover drug legislation enforcement, how to handle those who sell or use drugs, and how to identify illicit drugs.

QPF officers have long been involved in 'alcohol work' and this new development will be along the same lines. It will be supplementary to, not a substitute for, the work of the RCMP whose anti-drug involvement is more with large-scale criminal operations. With the upgrading of training for provincial police officers, a significant tightening of control over illicit drug traffic is expected.

"The RCMP have been doing anti-drug work for a long time and they know their job well," says Captain Gerard Charest who heads Montreal's 36-man drug and morality squad.

"Our men too should be knowledgeable and know what to do with respect to drugs. Say if we stop a suspicious car or even on a routine assignment, our men should be fully informed about what to look for and how to handle this particular aspect of crime."

For some 200 members of the QPF's alcohol and morality squad, in 15 detachments across the province, this is not a new development. They were already involved in anti-drug work.

However, the QPF maintains 110 posts in this large province, staffed by 4,200 people. To date only a few from each of these posts have received the Nicolet anti-drug instruction.

SWITCH TO CIGARS JEOPARDIZES HEALTH

MONTREAL—Ex-cigarette smokers who switch to cigars may be exchanging a bad health risk for a worse one, a Florida researcher told the International Conference on Lung Diseases, held here.

Dr Allen L. Goldman, Tampa, said: "Inhaled cigar smoke robs the blood of more oxygen than does inhaled cigarette smoke, and most ex-cigarette cigar users unintentionally continue to inhale."

Primary cigar smokers apparently do not inhale, he said, and have carboxyhemoglobin (carbon monoxide combined with hemoglobin in the blood) levels similar to non-smokers. However, a previous investigation showed that secondary cigar smokers (ex-cigarette smokers) have high carboxyhemoglobin levels which presumably reflect habitual inhaling.

To discover just how high such levels are, Dr Goldman performed a study in which 16 non-smokers, 24 inhaling cigarette smokers and 18 inhaling cigar smokers participated. All were lung disease out-patients at Tampa Veterans Administration Hospital where Dr Goldman is chief of the pulmonary disease section.

"Carboxyhemoglobin levels of the cigar smokers were as much as four times as high as those of the cigarette smokers and eight times as high as the non-smokers."

Carboxyhemoglobin interferes with the exchange of oxygen and carbon dioxide in the lungs, robs body tissues of oxygen, and contributes to hardening of the arteries.

"But," he said, "most of these cigar smokers were unaware of the potential harm of inhaling. So were their physicians."

Hallucinations reported

Musical withdrawal from alcohol

By THOMAS HILL

BAL HARBOUR, FLA.—More commonly than is generally realized, people who hallucinate during withdrawal from alcohol have the illusion of hearing music, according to Dr Robert A. T. Scott, associate director of the acute detoxification unit at San Francisco General Hospital.

The observation is considered important because awareness that musical hallucinations are fairly common in patients undergoing withdrawal may help doctors to differentiate such patients from those with other forms of "functional" psychoses.

"Confusion about the nature of alcoholic withdrawal hallucinations is evident in current psychiatric texts," Dr Scott told the American Academy of Neurology at its annual meeting here. Textbooks generally state that withdrawal hallucinations tend to be visual, in contrast to the auditory hallucinations of schizophrenia.

The work of several investigators in recent years has demonstrated the error in the general textbook concept, but has left the impression that although auditory hallucinations are common enough, they seldom include hallucinations of music.

Dr Scott found, on the contrary, that musical hallucinations are quite common. He has also noted they tend to occur in a definite temporal position in the sequence of events that occur during withdrawal.

"It may appear the problem is either semantic or pedantic," said Dr Scott, "but our experience in the acute alcohol detoxification ward of San Francisco General Hospital over the past four years has been that it is frequently quite real. Because patients with alcoholic auditory hallucinations may manifest the same behavior (paranoia, agitation, delusions of persecution, tangentiality and fragmentation of thought) as those with acute paranoid schizophrenia, it has frequently been very difficult to differentiate them.

"Many of our patients carry the diagnosis of paranoid schizophrenia simply because they have hallucinated or appeared paranoid during withdrawal in the past. Were the treatment similar for each, this might be no problem. . . ." But it happens the treatment is different.

Dr Scott said the phenothiazine drugs, commonly used in treating psychotic states, may exacerbate the withdrawal state, in addition to increasing the likelihood of seizures. On the other hand, the sedative hypnotic drugs, widely used in the treatment of alcohol withdrawal, are generally not effective when used to treat acute functional psychoses.

Dr Scott, also an assistant professor of neurology at University of California in San Francisco, examined and quizzed 70 patients who admitted having had hallucinations during withdrawal from alcohol. He was surprised to find that 44 of the 70 (or 63%) had experienced hallucinations of music.

In all instances, the hallucinations of music were related to withdrawal, usually after a binge of weeks to months. However, several patients mentioned their occurrence while driving home after a night's drinking, or during a period of abstinence after drinking for several days.

Summarizing what he had learned about these musical hallucinations, Dr Scott said:

- They tended to occur early during withdrawal.
- They were commonly followed by other auditory hallucinations, usually vocal in nature.
- Visual hallucinations and mixed auditory and visual hallucinations tended to come later.
- Although some patients found the musical hallucinations annoying and bothersome, most did not feel they were unpleasant. (Dr Scott suggested patients troubled by them might have experienced them on other occasions and would be aware they could presage unpleasant and perhaps even frightening hallucinations at a later stage.)
- The music was characterized by repetitiveness—a sort of chant-like quality involving the repetition of phrases or even whole songs.
- Some could relate them to environmental stimuli, such as the sound of a fan or an engine. Two patients reported thinking that the music came from radios or ducts in their room.

If musical hallucinations are so common in alcohol withdrawal, how is it that they have not been recognized in the past? Dr Scott speculates that, because they occur early in the course of withdrawal and are relatively benign, they tend to be overshadowed in the patient's memory by more frightening auditory and visual phenomena that occur later.

BACKFIRE

A DISTRICT of Columbia policeman whose work as an undercover narcotics agent required him to drink in local bars, has been retired on a full disability pension because of alcoholism. Police officials said the decision stemmed in part from recent court decisions holding alcoholism as a disease rather than an offence. Assistant Police Chief Burtell M. Jefferson was quoted as saying: "You've got to distinguish between the man who drinks off duty and becomes an alcoholic and the man assigned to vice who has to drink alcohol."

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

First Annual Deep South School of Alcohol Studies—July 6-11, Shreveport, Louisiana. Information: Sam D. Thomas, Director, Deep South School of Alcohol Studies, Centenary College, P.O. Box 4188, Shreveport, Louisiana 71104.

Triennial Refresher Course for Alumni of Rutgers Summer School of Alcohol Studies—July 13-17, New Brunswick, N.J. Information: Miss L. Allen, Secretary, Summer School of Alcohol Studies, Rutgers University, New Brunswick, N.J. 08903.

Sixth International Congress of Pharmacology—July 20-25, Helsinki, Finland. Information: Secretariat, Sixth International Congress of Pharmacology, Siltavuorenpenger 10, SF-00170 Helsinki 17, Finland.

Eighth National Conference on Alcohol and Drug Education—July 21-25, Ponteland, England. Information: Secretary, TACADE, 437 Royal Exchange, Manchester M2 7EP, England.

Behavioral Approaches to Alcoholism and Drug Dependencies—July 31-Aug. 1, Seattle, Washington. Information: Office of Short Courses and Conferences, DW-50, University of Washington, Seattle, Washington 98195.

Seventh Annual Summer School on Alcohol and Other Drugs—August 4-15, Berkeley, Calif. Information: Herman J. Kregel, Director, Berkeley Center for Alcohol Studies, Pacific School of Religion, 1798 Scenic Ave., Berkeley, Calif. 94709.

Seminar on Alcoholism—Aug. 6-15, Chicago, IL. Information: Ms. Mary Ellen Shallis, 122 S. DesPlaines Street, Chicago, IL 60606.

National Consultation on Problems of Alcohol and Drug Dependence of Women—Aug. 15-16, Quebec City. Information: Mr. D. Taylor, Executive Vice-President, CFADD, 451 Daly Ave., Ottawa, Ont. K1N 6H6.

Institute on Addiction Studies—August 17-22, McMaster University, Hamilton, Ont. Sponsored by Alcohol and Drug Concerns, Inc. Information: David Reeve, 15 Gervais Drive, Don Mills, Ont.

New England School of Drug Problems—Aug. 17-22, University of Vermont, Burlington, VT. Information: Jan S. Durand, Coordinator, P.O. Box 11009, Newington, CT 06111.

Fifth International Conference of the International Association for Accident and Traffic Medicine and the Third International Conference on Drug Abuse of the International Council on Alcohol and Addictions—Sept. 1-5, London, England. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders—Sept. 1-12, Toronto, Ont. Information: P.O. Box 1975, Station "B", Ottawa, Ont. K1P 5R5.

1975 Annual Meeting of the Alcohol and Drug Problems Association of North America—Sept. 14-19, Palmer House, Chicago. Information: Alcohol and Drug Problems Association of North America, 1130 Seventeenth St., N.W., Washington, D.C. 20036.

Canadian Foundation on Alcohol and Drug Dependencies—Sept. 14-19, Quebec City. Information: OPTAT, 969 Route de l'Eglise, Quebec 10e, P.Q. G1V 3V4.

Ontario Consultation on Women, Alcohol and Drugs—Sept. 29-Oct. 1, Ottawa, Ont. Information: Ms. L. Pinder, ARF Regional Office, Suite 202, Pebb Bldg., 2197 Riverside Dr., Ottawa, Ont. K1H 7X3.

Interdisciplinary Conference on Conjoint Emergency Care—hosted by the Emergency Nurses Association of Ontario—Oct. 1-3, Toronto, Ont. Information: Ms. M. Victoria Eld, Apt. 5, 62 Old Mill Road, Etobicoke, Ont. M8X 1G7.

Symposium on Headache—Oct. 4, Toronto, Ont. Information: The Director, Office of Postgraduate Medical Education, University of Toronto, Toronto, Ont. M5S 1A8.

49th Annual Convention of the American School Health Association—Oct. 8-12, Denver, Colorado. Information: American School Health Association, ASHA National Office, Kent, Ohio 44240.

International Symposium on Alcoholism—Oct. 11-13, Porec, Yugoslavia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

First National Conference on International Conference on Alcoholism and Drug Dependence—Oct. 26-Nov. 1, Sao Paulo, Brazil. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Third Annual Conference of the California Association of Alcoholic Recovery Homes—Oct. 31—Nov. 2, Asilomar, Calif. Information: Joe Collins, Executive Director, CAARH, P.O. Box 5396, Santa Monica, Ca. 90405.

Positions Available

THE NARCONON STORY

BETTY LOU LEE CONCLUDES A SPECIAL TWO—PART REPORT

TORONTO—Lyle was a pioneer in the Toronto street drug scene, in on the start of the heyday that was Yorkville. At 28 years old, he is an eight-year veteran of speed use. He has been off it for only a few months.

As he talks at Narconon headquarters in Toronto where he's been living for about a month, he is calm, clear-eyed and articulate. He has been taking the basic communications course offered by Narconon since his arrival, and expects to finish it the next day.

He came to Narconon after two months as a patient at the Addiction Research Foundation clinic in Toronto, and says a nurse there recommended Narconon to him.

"I had been physically withdrawn from drugs, and had had a few passes out (from ARF) with no drugs. . . . In their opinion, they did as much as they could for me in that setting. I was very disappointed in relation to what had been promised me when I went in," he says of ARF.

"I broke all ties from what I had and had no place to go, no job, no assistance. They gave me less than two weeks to leave."

Gadgets

They had assessed one of Lyle's big problems as talking too much and communicating too little. When he started rambling on at the clinic, other patients would click little gadgets as a signal for him to shut up: He was not to say another word. That shut him up, but he says it didn't teach him much about communicating properly.

As soon as Lyle left the ARF clinic, he was approached by two girls who deal in speed. "I was in a state of panic and I rushed up here. I spoke to some people downstairs and after a couple of hours I became more relaxed, more convinced I wasn't going to go out and get some speed."

Asked about his daily routine, Lyle answers precisely and in detail, accounting for every hour between his getting up at 7:30 a.m. to going to bed about midnight. He prepares all the meals at the house, and spends a total of 7¼ hours a day on his course in morning, afternoon and evening sessions. The city social services department covers his $30 weekly room and board.

His attitude is a confident one as he sits without fidgeting or aimless gesturing, looking the interviewer in the eye and answering questions directly. His conversation has few of the "you knows" and "ers" that so often link the phrases of the young.

Asked how he is using Narconon training in the present situation, he replies: "For a more congenial flow of conversation. I'm able to answer your questions without going off the subject. . . . Before, I'd forget what I was talking about and go off on tangents. . . . Sometimes when I was on drugs, by keeping on talking I could keep myself from passing out."

Cooking

He expects to go on to another Narconon course after completing the communications one, and is considering becoming a Narconon employee. He has paid the organization no money other than his $30 room and board, has signed no contracts or promissory notes. His cooking has been his contribution for his training.

He does not attend the Church of Scientology, and maintains an "off and on" relationship with the High Anglican faith in which he was raised in small-town Ontario.

If, for some reason, he could not stay on in the Narconon program in Toronto, he thinks he would go to another city which has street programs.

He feels he is not yet ready to cope without Narconon, "but I know I'll get there. . . . I would fare better now than I would have a few months ago, but there's a possibility that with some money, I might return to drugs. I have a problem with drugs and that problem isn't going to be eliminated overnight."

Lyle is one of 300 to 350 students whom Narconon's national director, Joe Keldani, estimates have taken part in the program in Toronto since 1971. Mr. Keldani figures that no more than a total of "a couple of hundred dollars a year" has been collected from them. "Druggies don't have money."

Narconon focuses on getting donations from the community to carry on the program, rather than from the students taking part in it, he says.

A man approaching 30 years of age, Joe Keldani left a mathematics and physics course at university a year before completion to become national director of Narconon. His manner is intense, his speech at times almost staccato as he talks of the program that he is convinced works.

His main goal is to get the program established across Canada.

He expects to raise $100,000 in Toronto this year—double the amount the program collected last year, and five times what it had to work with in 1973, its first year after incorporation.

Asked who the contributors are, he replies that the list is about 5,000 long, but includes such corporations as IBM, CPR and Kodak, who sometimes give "a couple of thousand".

In a financial statement for 1973, Narconon lists $10,563 in donations from "groups and individuals", plus specific donations of $200 from CPR, $500 from IBM, $200 from Imperial Oil and $1,700 from "Archbishop Pocock and the Roman Catholic Church".

Mr. Keldani says he is unsure if the latter donation was from the Archbishop's personal funds, or from the church. The archbishop's office says it was a personal donation.

Bills

The rest of the 1973 income included $2,274 worth of bills that were paid by the Church of Scientology of Toronto, and $5,000 for room and board from students, most of that via the Toronto welfare department.

The biggest single expense in the $18,416 total was $6,492 for salaries. Rent, food, fuel, maintenance and office expenses took the rest.

Of last year's $50,000 revenue, the biggest chunk was a $30,000 National Housing Act grant to make a down payment on the $140,000 house at 157 Spadina Road that was officially opened in May.

In some parts of the country, $140,000 would sound like enough for a mansion. In Toronto it bought a house that would have sold for less than $50,000 a few years ago before the city's real estate market took off for Mars. It is a 2½-storey brick home, probably about 50 years old.

Mr. Keldani says there is a $110,000 mortgage on it, backed by Central Mortgage and Housing Corporation.

Narconon literature explains that the cost of maintaining a student on its program is about $1,000 a year—half of that if the student is in prison. One of its pamphlets says a $25 donation gives the donor a one-year contributing membership, and $100, five years.

For a $1,000 founding membership contribution you may found a new Narconon program "in the name of your choice". Since Narconon is registered in Canada as a charitable organization, donations can be used for income tax deduction purposes.

Helen Bell, social coordination director for Narconon, gives the following explanation of payment arrangements with students: "The person may or may not pay for his courses. If he has the cash, he pays for each segment of the training that he wishes to take. If he does not have the money, the registrar works out a schedule of work that will pay for his training. . . . In all cases, we insist on some kind of exchange as you cannot rehabilitate anyone who feels they should receive something for nothing."

The price list she supplied includes a basic program that totals $925 a la carte, but has a package price of $800. That includes "withdrawal, if needed" at $300, but Mr. Keldani says this is not used anymore.

People are able to withdraw from drugs with little physical or emotional discomfort on the program, he maintains. Rest, good food and vitamins are part of the initial approach, and in rare cases "a touch assist" is needed in case of pain.

This involves putting a finger on the person's arm or leg. "With his eyes closed, you ask if he can feel your finger, and when he does. . . . the person will feel a charge go through, and he'll realize something, and he'll be happy and the pain will be gone. Unless he's in extreme, heavy, heavy pain which you don't bother with. You send him to a doctor."

The communications course, the first and basic one in the Narconon program, is $25. If the student is living in—and the majority do not—his weekly room and board is $30 if he is on welfare, less if he gets a job, as an incentive to becoming self-sufficient.

"Most of the people on drugs are either on welfare or they're on the street bumming, or prostituting, or whatever," says Mr. Keldani. "One of the most important things is to get them to produce . . . it's one of the most beneficial things that can happen to someone on drugs."

Intensive

For most people, he says, the communications course is all that is needed, and it takes three to six weeks of intensive training to finish it.

It is described in Narconon literature as "the preliminary step to the courses which follow, that progressively enable the student to handle life more successfully."

It consists of nine training routines repeated with a coach until they are fully understood and can be done without a "flunk".

Communication is defined as "the consideration and action of impelling an impulse or particle from source-point across a distance to receipt-point, with the intention of bringing into being at the receipt-point a duplication of that which emanated from the source-point."

The first drill consists of sitting three feet from a coach, eyes closed, without speaking, moving or twitching. As the course progresses, the student should be able to do this for two hours, and its purpose is "to get the student to BE there comfortably, . . . and not do anything else but BE there."

As the drills continue, they are designed to train someone to stick to the point, and not be distracted by verbal or other diversions; to wait for the person spoken to to acknowledge he heard; and in turn to acknowledge his acknowledgement.

A student and coach, for example, may go 50 rounds of the student asking "Do birds fly?", to which the coach should reply "Yes", and the student respond "Good". If the coach throws in any other comment or question and the student responds to it, the student "flunks" and they begin again.

"Even though the same question is asked, it is to be asked as though it had never occured to anyone before."

Participants alternate in the coach-student roles in these drills, on a one-to-one basis. Supervisors make sure they are doing them exactly right, and conduct the final tests.

Each training routine has a list of definitions, which the student must demonstrate "using bits and pieces of anything available". The definitions range from something as simple as "terminate—to end, stop", to "buttons—items, words, phrases or subjects which cause a person to be embarrassed, uncomfortable or upset or to make him laugh uncontrollably".

Many of the routines in this course were developed by L. Ron Hubbard, the founder of Scientology. The last four drills are designed "to bring about in the student the willingness and ability to handle and control other people's bodies, and to cheerfully confront another person while giving that person commands. Also, to maintain a high level of control in any circumstances."

Coaching instructions note that "once in a while the student will start to rationalize and justify what he is doing if he is doing something wrong. He will give you reasons why and becauses. Talking about things at great length does not accomplish very much. The only thing that does accomplish the goal of the TR (training routine) and resolves any difference is doing the training drill. You will get further by doing it than by talking about it.

'Misemotion'

"These training drills occasionally have a tendency to upset the student. There is a possibility that during a drill a student may become angry or extremely upset or experience some misemotion (unreasonable or inappropriate emotion). Should this occur the coach should not back off . . . but push the student through whatever difficulty he may be having."

Other courses listed by Helen Bell are "objective orientation, $100; basic study manual, $60; Anatomy of the Human Mind, $25; Hubbard Standard Dianetics Course, $500, and Drug Run-Down Co-Audit, $200."

A copy of a "volunteer program contract" signed with Narconon (the city is unspecified) is an agreement to work, in this case for two months, for Narconon in order to get the following training: Basic study manual, $75; withdrawal pack, $100;. "Mini Crse Supervisor's Crse", $150; Ethics Officer Mini Hat, $150, "and any other specialist training required. If there is any breach in this agreement. I will pay the ascertained amount of these courses."

Donations

Parental consent is required for anyone under 18 years in the program, and a Narconon assent form contains the clause: "I hereby agree that the cost of the counselling/training received by my child/ward shall be paid by me at current rates without discount forthwith on demand." There is no designated place on the form to state what the cost will be.

In practice, however, says Mr. Keldani, most students "make a $2 deposit and that's it".

"We arrange something for the person to pay if it's possible. If it isn't possible, you work out something with the person anyways. The people who have benefitted most from the program have been people with some form of exchange". That exchange could be helping with work at the house, or soliciting donations, for example.

"It's a matter of getting people off drugs and that's what we're here to do. The only thing we're interested in about money is having enough to run this place, pay the rent and food."

His own salary last year was $5,000. "And you know what I averaged putting in my pocket that didn't go back to the Narconon program?—$12 a week. Or was it a month?" He says if he weren't subsidized by his businessman father, he wouldn't be there.

Dianetic

He estimates salary costs this year will be $50,000 to pay 13 full-time staff members.

For a staff member to be "fully trained in dianetic auditing—one-to-one counselling" involves six to seven months of training, 12 to 13 hours a day. "In some cases, that's free, if they cook, or go out for donations, or help in the program."

What happens if a family is willing to finance a student?

"For everything that you could possibly take at Narconon we would ask for a donation of $925. But actually, the way we do it, is say: 'Why don't you buy the communications course?' Then if she is doing well on that course, you can give whatever donation you think is feasible.

"Usually it's a lot higher than the $25 when they see what's being done. Most of our corporate donations come from people who are connected to people who have gone through the program. . . . So she goes through the communications course . . . they look and say: 'Hey, she's doing great. What else have you got there?' "

Canadians have hearty appetite for alcohol

OTTAWA — Despite the ravages of inflation and the government's sporadic anti-drinking campaigns, Canadians continue to guzzle more and more alcohol each year.

According to Statistics Canada, sales of all alcoholic beverages increased a hearty 11.2% in the fiscal year ending March 31, 1974.

Canadians visiting their provincial liquor and beer stores and (where permitted) private wine stores, spent $2.6-billion, or $263-million more than in the previous year.

This represented a consumption of some 475-million gallons in a year, or more than 20 gallons for every man, woman and child in Canada.

By volume, the consumption increase is not as marked: only 6% which seems to make more sense at a time of high inflation when Canadians would be expected to cut back on expensive luxuries.

It also underlines the stake the federal and provincial governments, who set prices and collect both taxes and profits from alcohol sales, have in the continued popularity of drinking.

Statistics Canada reports (at the very end of soon-to-be-released publication on the control and sale of alcoholic beverages in Canada) that provincial government revenues from the alcohol sales rose 10.8% to $825-million.

Meanwhile, the federal government take rose 10.9% to $554-million.

By sales value, spirits continue to outsell both wines and beer.

Some $1.25-billion worth of spirits were sold compared to $302-million worth of cider and wines and $1-billion worth of beer.

Compared to the previous year, the value of sales of spirits was up 12.5%, of ciders and wines up 14.7% (in part reflecting the increased cost of imported wines), and of beer up by 9%.

Of spirits, whisky was easily the top seller, chalking up roughly half of all spirit sales with a value of some $618-million.

Far down the list was rum, second with sales of $178-million, followed closely by gin with sales of $160-million. Vodka was next with $105-million in sales.

Liqueurs and brandy were next, with $68-million and $65-million in sales respectively.

By province, Ontario residents swallowed 37% of alcohol (by

See — Canadians — Page 3

The Journal

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Drinking at sea may be responsible for a dramatic number of accidents at sea — details page 2

Crackdown on motorists in Britain

By ALAN MASSAM

LONDON — Much stricter penalties for drinking and driving offenders are on the way in Britain.

At least that is the interpretation being given to a surprisingly outspoken speech by Britain's newly-appointed Minister of Transport Dr John Gilbert.

Making his first public pronouncement since he took office in June, Dr Gilbert revealed he strongly favors a crackdown on drinking-driving offenders.

He said: "I am sick and tired of the man who has lost his licence through drink and drive being the object of sympathy among his friends. He should be regarded as a highly dangerous criminal. In the 16 to 24 age group driving under the influence of drink is the biggest single killer we have. I am determined to do something about it."

Dr Gilbert predicted that stiffer penalties would follow the report by an official committee reviewing Britain's breathalyzer laws.

He said: "My general view is that there are far too many loopholes in the law that have been exploited. There are problems of enforcement. There is some question of whether the police have sufficient powers and whether the penalties are adequate."

The Minister was subsequently reported here to be expressing favor for recommendations made by British Medical Association experts to the breathalyzer law committee.

It is believed the committee is considering suggestions that drivers found to have twice the legal limit of alcohol in their blood

See — Crackdown — Page 2

Roadside breathalyzers

Drinking drivers beware!

OTTAWA — Justice Minister Otto Lang has introduced federal legislation designed to allow police to catch more impaired drivers and to reduce the amount of drinking and driving continuing in Canada despite breathalyzer tests.

Under proposed amendments to the Criminal Code, police would be able to set up roadside breathalyzers instead of having to haul a suspected drunken driver off to a police station equipped with a breathalyzer machine.

See Editorial Page 8

Just as important, police would be able to require persons suspected of having any amount of alcohol in their blood to take the breathalyzer test, to see whether they have 0.08% or more alcohol and are therefore legally impaired.

At present, police may only intervene when they suspect the driver is actually legally drunk.

Thus, under the new legislation, police could establish checkpoints near bars or parties where alcohol is being served, and then require all drivers leaving the establishments to take a breathalyzer test on the spot.

Recent federal studies have suggested that a significant number of drivers on the highways at night have been drinking and that 5% or more are actually legally drunk.

Mr. Lang said the legislation, which also features stiffer penalties for drunken drivers, is intended primarily to increase the risks of being caught for drinking drivers, and thereby reduce drinking and driving in Canada.

The legislation would also increase the penalties for drunken driving to a level comparable to those in effect for impaired driving.

The minimum jail sentence for a second offence of drunken driving (0.08 alcohol blood level or higher) would be two weeks. For third and subsequent offences, it would be a minimum of three months in jail.

The roadside breathalyzer spot checks would not come into effect until federal authorities have approved testing equipment in each of the provinces, meaning that they would likely be in force next year in some larger provinces but be delayed a year or two in smaller provinces.

Another proposed change would allow judges to grant special conditional discharges (like those now available for simple possession of cannabis) to drinking drivers in place of a conviction and sentence. The discharges would be conditional on the driver's agreeing to attend an approved alcoholism treatment facility.

Mr. Lang said this portion of the legislation would depend on the availability of provincial rehabilitation facilities. Again, it is likely it

See — Roadside — Page 2

Marie-Andrée Bertrand

"We're controlling almost nothing"

MONT GABRIEL, QUE.—A leading criminologist and former Le Dain commissioner has charged that 90% of drug use in Canada is uncontrolled.

"I would say we are controlling almost nothing. And in attempting to solve a problem, we have created another problem," Professor Marie-Andrée Bertrand told a conference here on drug addiction and the criminal justice system.

"If you look back at statistics over the years, you will see we have gone from 100 arrests to more than 30,000 yearly drug convictions. We have multiplied the problem by 3,000," she said.

Prof. Bertrand, who joined Canada's LeDain Commission in 1969 as a self-styled "liberal reformer", later claimed that "working on the commission together with my own research has radicalized me considerably".

The author of two minority reports to the commission's four reports, she recommended legal sale of synthetic opiate derivatives through special clinics to known addicts and that possession or use of any drugs should not be an offence.

She told the conference: "Studies have shown we are dealing in our courts with 10% of drug users. Actually, only a small percentage of these are the real drug addicts and we are not getting at that problem at all, or scarcely

See — Hide — Page 3

. . . INSIDE

SAILING A HAZARDOUS COURSE

HAMBURG — Drunken driving is a serious matter, but drunken sailing does not even rate as a misdemeanor.

That has to change, according to Prof. Werner Janssen, director of Hamburg University's Institute of Forensic Medicine, for "the consequences of intoxication at the rudder are often greater than those of inebriation behind the wheel of a car".

(In Canada between 1968 and 1972, there were 6,500 drownings—alcohol was implicated in 42% of boating drownings and 28% of drowning by swimmers.)

Moreover, says Janssen, whose institute has just completed a study of alcohol-related ship accidents, drunken sailing and seafaring are on the increase.

Janssen even believes alcohol was a factor in the 1956 collision of the Italian liner Andrea Doria and the Swedish ship Stockholm which took the lives of 51 passengers.

Drinking on board ship by officers and crew, according to Janssen, is an old and widespread problem. To deal with it, in an era when sea lanes and inland waterways are becoming increasingly crowded and the size and speed of vessels is growing, he recommends imposing an international 1.3 per mille blood alcohol limit on all those involved with the steering and engine operations of any ship.

To support their theories, Janssen and his team of researchers investigated 64 shipwrecks and collisions, over a 13-year period, in which alcohol consumption had been suspected.

Basing their survey on deductive analysis of collision reports, witnesses' statements, and investigations conducted by insurance examiners, they determined that blood alcohol values of .7 to 4.0 per mille were involved.

In a related study, Janssen's team investigated the fatal deaths of 82 sailors and port workers over a 10-year period in Hamburg Harbor. All 82 had died by falling into the water. Post-mortem examination showed 64 had been intoxicated.

The Janssen survey included a number of case studies.

One of the most shocking involved a Liberian coastal freighter observed going in a circle for hours in the estuary of the Elbe. When German coastal patrol officials finally succeeded in boarding it, they found "the rudder locked in a hard starboard position, the engine-room telegraph set on slow-speed forward, and virtually the entire crew drunk in its bunks and cabins". The captain had a 3.4 per mille blood alcohol rating.

There being no legal limitations, says Janssen, the most courts can do is convict skippers of "reckless" or "careless" command of their ships.

But cameraderie among seamen, the lack of solid evidence and the absence of clear legislation makes such cases hard to prove, he says.

Justice Minister Lang

Roadside screening

(continued from page 1)

would come into force quickly in larger provinces such as Ontario that already have alcoholism rehabilitation facilities and be delayed in smaller provinces lacking such facilities.

Since the conditional discharge is not a conviction of guilt, this section could play havoc with provincial legislation which require suspension of driver licences in cases of convictions of drunken driving. Mr. Lang said he expects provincial legislation to be modified before the conditional discharge provisions come into force, though he hopes the provinces will not automatically suspend the licences of those persons voluntarily accepting treatment as part of conditional discharge.

The major change in the legislation (which will not be considered by the Commons until the fall session of Parliament) gives a policeman the right to require a driver to take a breathalyzer roadside test if the policeman has "reasonable cause" to believe the driver has been drinking.

Thus, the policeman would not have to have reasonable grounds and believe the driver was already impaired.

The penalties for drunken driving would be a maximum of a $2000 fine or six months in jail or both, or a minimum of a $50 fine, for a first offence; jail for not more than one year and not less than 14 days for a second offence; and jail for not more than two years and not less than three months for subsequent offences.

The penalties would be the same for persons refusing the take the roadside breathalyzer test on demand of a police officer who has "reasonable grounds" to believe the individual has been drinking.

Crackdown

(continued from page 1)

(British legal limit is 80 milligrammes of alcohol per 100 millilitres of blood) should be banned from driving again until they have established their fitness to hold a driving licence.

Such drivers would have to apply to a court for a restoration of the licence and might be required to submit to medical treatment at an alcoholics' centre to "prove" their psychological suitability. This, in effect, amounts to forcing drivers with a drinking problem to take a compulsory cure. It is suggested that they should be denied a driving licence for between three and five years.

These changes in the law, if carried out, would completely satisfy the medical critics at BMA house who have become increasingly critical of Britain's record of drinking and driving fatalities.

A government report last year showed that 40% of drivers and motor cyclists killed in road accidents had a blood alcohol level above the legal limit.

California reduces pot penalities

By SAUL ABEL

LOS ANGELES — Capping a long and often bitter battle over marijuana law reform, the California legislature has passed, and Governor Edmund G. Brown, Jr. has signed into law, a measure sharply reducing penalties for possession of small amounts of the drug.

The bill, authored by State Senator George R. Moscone of San Francisco, was approved by the Assembly on a 42-34 vote.

— See Backgrounder page 9 —

Only six weeks earlier, the measure suffered a surprise defeat in the same chamber. Assemblyman Alan Sieroty of Los Angeles, floor manager for the bill, won approval of a motion to reconsider "in due course". When the second roll call took place, the additional votes required for passage had been mustered.

During debate on the bill, Sieroty sparked a wave of laughter in the assembly by remarking "our laws are way out of joint".

When the new law goes into effect January 1, 1976, California marijuana penalties, among the harshest in the nation, will change dramatically.

At present, California is one of only four states that permit simple possession of small amounts of marijuana to be treated as a felony with maximum sentences of one to 10 years imprisonment.

Under the Moscone bill, possession of one ounce or less becomes a misdemeanor, subject to a maximum $100 fine. Traffic-type citations would be issued, and arrest and conviction records would be automatically purged after two years.

Furnishing or transporting not more than one ounce also become misdemeanors, punishable by a fine of not more than $100.

In an interview with **The Journal**, Senator Moscone expressed satisfaction with the new legislation, and stated he has no plans for further pursuit of drug, alcohol or marijuana liberalization.

"Personally, I favor decriminalization of marijuana," he said, "but I don't see that happening for some time."

Drawing a distinction between decriminalization and legalization, Senator Moscone said legalization would permit and promote commercialization. Decriminalization, in his view, would encourage the development of individual responsibility for private behavior and morality.

California's action is expected to have a significant influence on several other states considering marijuana law reform.

Just days before enactment of the California law, Maine became the second state in the nation to make possession of small amounts of marijuana a civil rather than a criminal offence. Oregon was the first to do so.

Senator Moscone

To relieve withdrawal

Acupuncture study begins

BY MILAN KORCOK

TORONTO — A pilot project assessing the effectiveness of acupuncture to relieve the withdrawal symptoms of drug addiction, has started at Toronto General Hospital.

The research team, headed by staff psychiatrist Dr. Albert Leung, hopes to involve up to 50 addict-subjects in the studies — half of whom would serve as controls.

The study will be open to individuals addicted to narcotics such as opium and heroin, barbiturates, other sedatives and analgesics, and alcohol.

The intent of the study is to assess acupuncture as an option to existing drug substitution withdrawal methods.

At a press conference called to announce the study, Dr. Leung noted the use of acupuncture in treatment of withdrawal and other manifestations of addiction is under investigation in other parts of the world. And he claimed preliminary results of such studies were encouraging, particularly those by Dr. H. L. Wen, consultant and chief neurosurgeon of Kwong Wah Hospital in Hong Kong.

Dr. Wen attended the press conference and offered advice on the research methodology to be used. Dr. Wen interned at the Toronto hospital in the late 1940s.

The project had been designed to accept drug addicts and alcoholics over the age of 16, who demonstrated good motivation to be drug free, who were otherwise healthy, and not pregnant.

The experimental group will receive acupuncture treatment, with electrical stimulation, to the auricular "Lung" points of each ear, and possibly to the "Spleen 6" points of the ankle.

Treatments will follow a short detox period from the standard drug substitution program, and will occur three times daily for three days, then once daily — as needed — for a further four to seven days.

Treatment will be given in the hospital's psychiatric ward and will require patients to stay in hospital for about 10 days. A qualified acupuncturist from China will give the treatments.

Patients are expected to be referred to the program from individual physicians in the Toronto area, and from the emergency departments of the area hospitals.

The research project, funded by the Ontario Ministry of Health, was approved last April and will continue to the end of this year.

H. D. Archibald

ARF director going to Geneva

TORONTO — H. David Archibald, executive director of the Addiction Research Foundation of Ontario, will leave the foundation Sept. 1 for a sabbatical year with the World Health Organization in Geneva, Switzerland.

In Geneva, Mr Archibald's work will concentrate on the potential and actual roles played by international agencies in the development of alcohol and drug policies and programs in specific countries.

One important focus of his interest will be Central and South America, although he will be based primarily in Geneva.

"Alcohol is the most important drug of abuse in most countries in this area although other drug substances are also a matter of growing concern," he said.

"I will be particularly interested in looking at the ways in which the collected research knowledge and program experience already existent in the international field, can be effectively made accessible to government, health, and education officials with a mandate to develop programs at the national level."

Development of a closer working relationship between ARF and WHO has been under way for some years.

"In fact, when the foundation expanded to include officially, drugs as well as alcohol in 1961, we became a prototype and reference point for WHO in international consultations and development," said Mr. Archibald.

Dr Wilfrid Boothroyd, a psychiatrist and the foundation's Senior Medical Consultant for the past five years will be acting executive director of the ARF in Mr Archibald's absence.

	Value				Volume			
	Spirits	Wines	Beer	Total	Spirits	Wines	Beer	Total
		($000)				(000 gallons)		
Nfld.	25,183	3,124	40,685	68,992	625	2002	10,387	11,214
P.E.I.	8,059	998	5,371	14,428	208	87	1,555	1,850
N.S.	49,944	8,485	40,015	98,444	1,284	754	12,188	14,226
N.B.	30,984	5,637	32,250	68,871	775	536	9,264	10,575
Que.	225,957	89,209	267,139	582,305	6,225	7,867	123,821	137,913
Ont.	478,605	105,714	382,573	966,892	13,848	9,038	154,148	177,034
Man.	65,266	10,217	45,654	121,137	1,865	1,134	16,693	19,692
Sask.	58,425	6,558	36,663	101,646	1,621	714	12,495	14,830
Alta.	122,171	23,719	81,246	227,136	3,114	2,258	27,088	32,460
B.C.	174,584	46,614	115,580	336,778	4,934	4,577	44,112	53,623
Yukon	2,560	891	2,168	5,619	64	40	579	683
N.W.T.	4,357	813	2,534	8,704	93	66	711	870
	1,246,095	301,979	1,052,878	2,600,952	34,656	27,273	413,041	474,970

Fiscal year ended March 31, 1974

Gov't purses fattened by alcohol sales

By BRYNE CARRUTHERS

OTTAWA — Federal and provincial governments collected $1.4-billion in revenues from the control, sale and taxation of alcoholic beverages in Canada during the fiscal year ending March 31, 1975, according to Statistics Canada.

This represents more than half of the $2.6-billion worth of total sales of alcoholic beverages in Canada.

And, perhaps not surprisingly, the largest single slice goes to the federal treasury: $554-million.

The statistics also suggest that the federal treasury has a much larger stake in the manufacture and sales of the higher-proof alcoholic beverages.

Statistics Canada estimates that the total federal revenues from excise tax, licences and import duty on spirits during 1973-74 was $357-million, compared to $19-million on wines and $177.5-million on beer.

Yet sales of spirits on a value basis are only 20% higher than sales of beer. And on a volume basis, beer outsells spirits by almost 12-to-1.

The fact that on a volume basis the sale of spirits increased by almost 12% compared to an increase of almost 6% for beer, suggests that if the federal intention is to discourage the sale of the more potent beverages with higher taxes, then it isn't working.

At the provincial level, Ontario collected $282-million from the control, taxation and sale of alcoholic beverages.

Quebec was second with revenues of $165-million, followed by B.C. with $109-million.

Prince Edward Island, the smallest province, had the lowest take: $5.9-million.

Canadians drinking more

(Continued from page 1)

value), imbibing $478-million worth of spirits, $105-million of wines and $382-million of beer.

Quebec was second, with sales of $225-million in spirits, $90-million in wines (mostly imported), and $267-million in beers (making Quebeckers the leading beer drinkers in the country).

Total sales in B.C. amounted to $337-million; $227-million in Alberta; $121-million in Manitoba; $101-million in Saskatchewan; $98-million in Nova Scotia; $69-million in Newfoundland (most of it beer); $68-million in New Brunswick; $14-million in Prince Edward Island; and $14-million in the Yukon and Northwest Territories.

Canadian wines represented only 49% of total sales, while Canadian-made beers chalked up 96% of sales. Canadian-made spirits captured 77% of the Canadian market.

In fact, Canada continues to be a successful exporter of spirits and seems to be making inroads in the beer export business as well.

Canada exported $234-million worth of spirits while only importing $60-million.

Canadian beer exports were up 30% to $6-million, compared to $3-million in imports.

But the Canadian wine industry continued to suffer at the hands of imported wines. Imports jumped 41.5% to $63-million. Canada managed to export $300,000-worth of wine.

Treatment specialists pessimistic: study

By JEAN MCCANN

HELSINKI — A survey of more than 30 years of literature on alcoholism shows that treatment specialists are becoming more pessimistic — or perhaps realistic.

At least the proportion of glowing success stories has gone down, Kai Pernanen of the Addiction Research Foundation of Ontario reported here.

A sampling of abstracts dealing with empirical alcohol research showed that 66% reported positive results between 1940 and 1954, while only 55% did so in abstracts published since 1964.

"In general", Pernanen told a general session here of the International Institute on the Prevention and Treatment of Alcoholism, "the discussion of outcomes tended to be more optimistic when NOT based on empirical research data."

He also reported on other trends in the review of 30 years of alcoholism literature which is part of a larger study aimed at correlating changes in society with changes in alcoholic treatment.

Some other trends seen by the ARF researchers:

- Empirical research has greatly increased "at the expense of descriptive or theoretical discussions of treatment in general, and specific treatment modalities." After 1969, such research reports made up 63% of the literature, as compared to only 26% in the 1940-1949 period.
- There is increasing criticism of "1) lack of consistent definitions of alcoholism, 2) choice of unrealistic treatment outcomes, and 3) inadequate methodology and design of projects".
- There is a decline in reports without supportive data from all types of treatment settings and modalities. Follow-up studies and control groups are also on the increase.
- Biochemical treatment modalities were most often mentioned throughout the 30-year period, possibly because changes can be more objectively measured with drug administration. Also, "fund-providers appear to be attracted to short-cut solutions... and the prominence of studies based on biochemical approaches may be a reflection of the strong medical orientation of many alcoholism treatment programs."
- Individual psychotherapeutic approaches are down, while group therapies are increasingly evident in the literature.
- Behavior modification approaches have been "in" during the period of study, but techniques have been widened to include more than aversion therapy.

Kai Pernanen

Mr Pernanen said these changes were culled from the Classified Abstract Archive of the Alcohol Literature published by the Rutgers Centre for Alcohol Studies, as a first step in determining factors which influence the prevalence of treatment modalities.

So far, he said, there is no clear-cut line of evidence over the last decades that one method of treatment is better than another.

"The lack of a cure, combined with the lack of a widely-accepted and sufficiently specific definition of the condition of alcoholism, provide a fertile background for extra-scientific influences on the development of alcoholics," he said.

'Reverse onus'

THE HEADLINE story in **The Journal**: Major Pot Law Changes Ahead (July 1, 1975) created the false impression that Canada's Senate Committee on Legal and Constitutional Affairs recommended elimination of the controversial "reverse onus" for those accused of cannabis possession for the purposes of trafficking.

A letter to **The Journal** from Toronto lawyer Clayton Ruby points out the Senate committee has not in any way eliminated or minimized the "reverse onus" which he and other criminal lawyers had argued for.

The new cannabis bill, approved by the Senate but awaiting final approval in the Commons, retains the "reverse onus" whereby the accused must disprove the crown attorney's allegation that possession was the purposes of trafficking.

The Journal regrets this error and thanks Mr. Ruby for the correct information.

"Hide and seek" situation

(Continued from page 1)

so. Maybe 1% to 2% of them."

She called heroin "our most embarrassing drug" and said that by prohibiting legal sources to addicts, Canada has created a hide-and-seek situation which not only gives the addict some satisfaction but also has become a part of his subculture.

"Whatever makes life bearable is accepted in our society today. Rehabilitation of the drug addict comes into the picture only when the addict has reached the bottom of the barrel and is pressured by legal, economic and other factors".

She suggested medicine has little to offer the addict at present and although some approaches are potentially valuable, the results they promise will apply to too few addicts.

Meanwhile, treatment facilities must be locally based and used as training grounds for new workers in the field, she said.

As for methadone, she said: "I am convinced this drug is also addictive and will never eventually lead the addict to live without drugs. Maybe substance substitution is a partial solution for some people — but only a partial solution".

On the question of drug use by prisoners, she said: "We should not blame anyone too much for the fact there are drugs in our prisons".

Nor should anyone be surprised. "We built those prisons. We created this situation.

"As for rehabilitation of the drug addict in any of our prisons, there is not enough incentive for a prisoner to change and give up drugs. Unless he is motivated by a religious conversion".

For the moment, she said, society is such that it will probably not allow for the elimination of drugs.

In the spirits

OTTAWA — Hard liquor consumption in Canada increased faster during 1973-74 than consumption of either beer or wine, on a percentage basis, according to Statistics Canada.

But despite the inroads of the spirit industry, beer continues to be the most popular alcoholic beverage in Canada.

Canadians consumed 413,041,000 gallons of beer during the fiscal year ending March 31, 1974, compared to 27,273,000 gallons of cider and wine, and 34,656,000 gallons of spirits.

But spirit consumption increased the most compared to the previous year, jumping by 11.65%, compared to a 7.5% increase for wine and 5.3% increase for beer.

Since spirits contain more alcohol by volume than wine, which in turn usually contains more alcohol by volume than beer, Canadians are actually increasing their alcohol consumption by closer to the 11.65% growth in spirit consumption.

Yet, beer still outsells spirits by almost 12 to 1. And the increase in beer consumption is evenly distributed across the country, in a fashion similar to the increase in spirit consumption.

Wine consumption continues to stagnate, with most of the increase in Canadian wine consumption the result of the continued brisk growth in the Quebec market.

For the statistically minded, Canadians drank some 17-million gallons of whisky, 5.6-million gallons of rum, 4.8-million gallons of gin, 3-million gallons of vodka, 1.7-million gallons of liqueurs and 1.5-million gallons of brandy.

Cider consumption amounted to 1.4-million gallons, compared to 3.4-million gallons of sparkling wines and 21.8-million gallons of other wines.

Gripe water - a potential for dependency?

By ALAN MASSAM

LONDON — One of Britain's leading agencies, the Avon Council on Alcoholism, with headquarters in Bristol, claims there may be a concealed dependency potential in what it describes as "non beverage alcohol".

In its fifth annual report, the council publishes the case history of a 42-year-old mother of three whose family sought help on her behalf.

The woman had all the classical visible symptoms of alcoholism. She was underweight, overtired and confused, and beginning to neglect her children. She admitted difficulty in sleeping, suffered loss of appetite and was experiencing extreme swings of mood.

The council report says: "There was one small problem which came up in the course of interviewing and the taking of a full case history from the woman and her family — SHE DID NOT DRINK BEVERAGE ALCOHOL.

"She did not approve of it, and furthermore was a member of a temperance movement connected with her church. Her family assured us she was not a secret drinker and that, though she had been under scrutiny for some time, they had never found any hidden or empty bottles around the house."

The explanation which emerged after further interviewing, was that the woman had suffered from indigestion four years previously and felt she needed medicine to ensure a good night's rest.

She had been unable to find any bismuth compound in the medicine cabinet but found there another preparation, described on the label as being "soothing for upset tummies". It was gripe water, for babies.

Assuming that what was good for babies would be good for her in larger quantities, the woman drank the gripe water and enjoyed a good night's rest. The following evening she repeated the procedure and soon became a regular user of the preparation.

By the time she was referred to the Avon Council, the woman was consuming between four and six bottles of the medicine daily.

As one who believed fervently in total abstinence as a guaranteed defence against alcohol addiction, she had been shocked to realize there were other ways of developing dependence.

The council report concludes: "Already we are thinking that perhaps the pleasant feeling and euphoria associated with the drinking of beverage alcohol did not start with the first drink in adolescence or teenage years. It now appears much more likely that the awareness of the availability of a mood altering substance was learned while in our prams and cots.

"The dangers of innocently forming a dependence on alcohol were highlighted recently in the magazine *Which?* when it was revealed that two popular brands of cold cure contained 15.4% and 18% respectively of alcohol.

"The impact on the mind made by the mood altering chemical substances contained in these preparations is often expressed by the user who says: 'I have taken my medicine and now I feel much better'. He may not BE better at all. He merely FEELS better. The effect of the drug has been to anaesthetise those senses that were registering the fact that he was unwell."

The Avon Council on Alcoholism's comments on gripe water as a risk of early alcoholism dependence were widely reported in the British press.

The manufacturers subsequently stated there was no evidence to support the supposition that giving the product to children at an early age might condition them to becoming dependent on alcohol.

They said the contents were shown clearly on both bottle and carton as being less than five parts in 100.

"Because many active ingredients are not soluble in water, a little alcohol has been used as a solvent in a very wide range of medicines for hundreds of years."

As for the suggestion the alcohol strength was twice that of beer, they said an average dosage is the equivalent of drinking two ounces of beer in 24 hours or one tablespoonful every eight hours.

"There is a wealth of medical opinion in favor of using this well-tried and tested medicine which has been used for the last 150 years."

There is no evidence to support the supposition made by the council that giving children the product at an early age may condition them to become dependent on alcohol, the manufacturers said.

Simple cannabis possession

CMA rejects proposed option to conviction

From Betty Lou Lee at the annual meeting of the Canadian Medical Association

CALGARY—A plan that would have allowed for an option to criminal conviction for simple possession of cannabis was rejected at the annual meeting of the Canadian Medical Association.

The CMA retained its stand that possession should remain unlawful, but should not be considered a criminal offence. It also passed a motion that it "continue to stress the definite health hazards that accompany the use of cannabis and that the public of Canada should be clearly advised against its use".

The diversion plan would have given those charged the option of volunteering for some type of counselling and/or treatment before a conviction was registered. The charge would have been withdrawn or dismissed if the accused had followed through.

The plan was overwhelmingly rejected by the general council.

It was submitted by the association's sub-committee on the non-medical use of drugs, headed by Toronto psychiatrist Dr Lionel Solursh; and the sub-committee on pharmacotherapy, chaired by Dr Ian Henderson of the University of Ottawa, a consultant to the federal Non-Medical Use of Drugs Directorate.

They saw it as an interim measure until the government could work out some method of establishing a non-criminal offence for possession, a process that could take years.

As Dr Henderson told the CMA general council: "We are asking that simple possession be made non-criminal, but that is not possible at this time in law. . . .the Narcotic Control and Food and Drugs Acts can only be administered by the federal government and it can only try offenders on the basis of the Criminal Code.

"The provinces and municipalities can issue parking tickets and such for which there is no criminal record, but the federal government is unable to do so by Canadian federal law. It may be that this can be changed, but it will take years to settle."

The Senate has recommended that cannabis be moved from the Narcotic Control Act to the Food and Drugs Act, and that an automatic pardon be given on conviction of a first offence for simple possession.

The CMA sub-committee's report noted that Senate recommendations "retain the potentially unfair application of fines amongst differing socio-economic groups, fail to provide an effective mechanism to expunge *all*(including police) records of criminality, and negate the current meaning of a pardon by making it automatic rather than investigative."

Dr Solursh said in the past year there have been 27,000 convictions for simple possession, up 47% from the previous year.

An attempt to criticize the CMA's position before the Senate Committee on Legal and Constitutional Affairs also got little support.

Dr J. W. Ibbott of Vancouver, president of the BC Medical Association, spoke for Dr Conrad Schwarz, Vancouver psychiatrist who has fought against relaxation of cannabis laws. Dr Schwarz is no longer on the CMA general council.

Dr Schawrz charged that CMA's involvement in "complex legal issues has obscured our fundamental message about the health hazards of cannabis."

He said the committee that appeared before Senate "had no mandate from the membership to talk about legal issues, just medical issues. A major opportunity to present a clear health warning was missed, and the idea given that doctors consider cannabis a somewhat innocuous substance."

Dr. Solursh

Dr Solursh said psycho-social aspects of cannabis could not be separated from the medical. "We have a right to be in this field."

Dr Bette Stephenson, retiring CMA president, was tight-lipped with anger as she said: "The emphasis on the health hazards was great (in the submission to the Senate). I have told this to Dr Schwarz at least four times in letters, and he has yet to respond to the last two."

She said a large number of people reviewed and approved the CMA brief to the Senate, including the Canadian Psychiatric Association.

A motion by Dr Ibbott that "henceforth the CMA confine public statements regarding cannabis to the associated health hazards" found little support from delegates.

Alcohol's effect on drinker may be determined by enzyme

CALGARY — The effect one gets from drinking alcohol may in part depend on the level of a particular enzyme in the blood, says Dr John Ewing, director of the Centre for Alcohol Studies, University of North Carolina.

The enzyme is dopamine beta-hydrozylase (DBH), which converts dopamine to norepinephrine. Dr Ewing describes its role as providing something like a thermostatic setting for the central nervous system.

In studying normal volunteers, he found those with a higher blood level of DBH got more stimulation from alcohol than those with lower levels, and they did not get as sick.

Allowed to drink as much as they wished in an experimental setting, the high DBH subjects drank an average of 9.58 drinks, the low DBH subjects averaged 5.43.

"They had good reason to go on drinking longer, because they didn't get as sick."

The level of DBH is an inherited factor, one of many now being investigated for possible etiological roles in alcoholism, Dr Ewing told the annual meeting of the Canadian Medical Association.

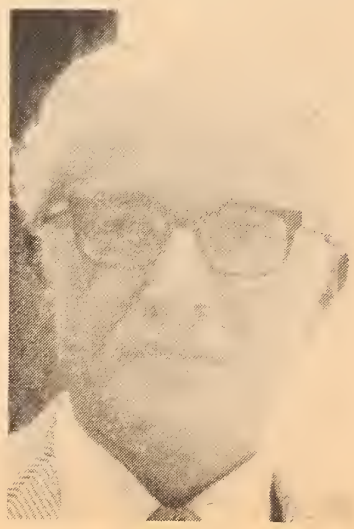
It may be there are genetic or racial factors that are protective against alcoholism, he speculated. If the low DBH people get sick, they are not likely to overconsume.

Similarly, studies he did on Orientals showed that 80% of them experienced flushing even with small amounts of alcohol, and there was a significant increase in their heart rate 30 and 60 minutes after alcohol consumption, compared to Occidentals.

"Alcoholism is less common among Orientals, and their physiological makeup may make alcohol excesses unacceptable. They are less relaxed and happy after drinking it."

He described alcoholism as a biopsychosocial phenomenon, and said its constitutional factors are just now coming under the type of scientific scrutiny that has been given the social and psychological ones.

"There are more than 30 genetic causes for dwarfism. Maybe the same situation is true in alcoholism, and we should refer to alcoholisms."



Dr. Ewing

Blood alcohol tests

Legal twists for MDs

CALGARY—A joint committee of the Canadian Medical and the Canadian Bar associations is going to study the legal ramifications of doctors performing blood alcohol tests.

The CMA agreed to the study at its annual meeting on the recommendation of its council on community health.

The council said it is a fundamental principle of medical practice that a doctor may do nothing to or for a patient without consent. But doctors are called upon to withdraw blood for alcohol estimations "on the request or implied command of a police officer".

It made the ethical position clear. "When a doctor is faced with a request to take a blood sample for alcohol, the patient must be informed of what is to be done. Not only must the patient consent to the venepuncture and the withdrawal of blood, but also consent to the release of the results of the test. It must be clearly specified to whom the results will be released."

If, however, the patient is unconscious, the doctor may want a blood alcohol test to help in diagnosis.

"The result of such a test may not be released by the doctor to police authorities, nor should they be informed that such a test was done."

The council pointed out, however, that with appropriate legal procedures, the results can be obtained from hospital records. "Council believes there is a need to examine the legal ramifications of this matter."

The same joint committee of the CMA/CBA will also review the criteria for conviction for impaired driving.

The council on community health noted that either alone or in combination, psycho-active substances may seriously impair safe driving ability. Section 234 of the Criminal Code outlines the impaired driving offence as including "alcohol or a drug".

But it said alcohol is the only mood-modifying drug for which legal limits are spelled out.

"When a fixed legal limit (e.g. 80 mg/dl) is prescribed, a new independent crime is introduced besides the other criteria, and this new crime may lead to the conviction of a person who has not caused any danger, for an object protected by law."

Dr John S. Bennett, coordinator of the community health council, said the object of the motion was to have the joint committee "take a look at the whole drugs and alcohol situation. A driver may be worse with two Valiums than he is with a few beers."

Tight money may force identity crisis

SAN FRANCISCO—The limited resources of the National Institute on Drug Abuse must be focused on the "unique needs of the drug abusing population", according to NIDA director Dr Robert DuPont.

Personnel in the drug field must deal with the realities of a substantially reduced budget, Dr DuPont told delegates at the Alcohol, Drug Abuse and Mental Health 1975 Conference here.

The reduction in federal funding will cause "reverberations throughout the field" and lead to an identity crisis, Dr DuPont predicted.

Consequently, there is an urgent need to provide "focus" for the drug field, he said.

Poverty, housing, family structure and urbanization are fundamental issues tied to drug addicition. But they are larger issues and not the specific concern of the drug field, Dr DuPont said.

Dr. DuPont

"We need to deal with the problems in the drug abuse field and make common causes with those dealing with these larger issues, not go over the line."

Dr DuPont emphasized the need for a balanced drug program, aimed at both reducing the supply of available psychoactive drugs and providing treatment for those who need it.

Supply is critical to the levels of use and consequent "people problems", he said, citing as an example the influx of Mexican heroin into Southern California.

"But those who say all you have to do is pass some laws miss the point."

In dealing with the human side of the drug problem, he said, it is "important to think positively and publically about drug problems represented by cigarettes smoking and alcohol".

Dr DuPont said he has stopped talking about "winning a war" against drug abuse and talks instead of "weeding a garden".

The "war" concept, he said, gives the false impression that by massing troops and pouring in funds, the problem can be stamped out.

The weeding concept, he now believes, is much closer to home.

On a related issue, Dr DuPont said talk of success leads the public and politicians into thinking the problem is gone, while any talk of lack of success leads to the thinking that, if the money already poured into the field has not helped, why bother.

He said his own oft-repeated comment that the US had "turned the corner against heroin addiction" has been "an endless source of humor".

"It is hard for many to realize that a dramatic reduction of heroin did occur on the east coast in 1972 and 1973", he said. Many do not believe this and consider his comment was politically motivated.

"But even sadder to me is that the public and politicians who heard the 'turning the corner' phrase, felt the problem had gone away" and the drug field required no further funds.

This, he said, represents a pattern of thinking — "if it is better, it doesn't exist and if it is worse, then it is out of control and you can't deal with it" — which is difficult to work with as "any description of improvement will be used as a rationale for cutting funds".

Pot and cold warning

CALGARY — The admonition, If You Drive, Don't Drink, has been around a long time, but a new corollary may be appropriate: If You Drive a Snowmobile, Don't Take Cannabis.

The danger is not only one of possible impaired perception, but of an impaired ability to adapt to cold, warns Dr Ian Henderson of the department of pharmacology, University of Ottawa.

Dr Henderson told the annual meeting of the Canadian Medical Association that "it may be important to recognize potential dangers for persons living in northern communities where low ambient temperatures can cause rapid body chilling in the absence of normal physiological mechansims."

Cannabis has hypothalamic effects that suppress shivering during exposure to cold.

"This could also be of importance for divers who enter cold water for either profit or sport . . . (and for) young people engaged in winter sports such as snowmobiling and cross-country skiing."

In experimental cats, administration of 1 to 2 mg/kg of delta-9-THC reduces body temperature by as much as 6 degrees Celsius.

For ignoring substance abuse

Med schools attacked

BURLINGTON, VT. — Medical schools are "grossly deficient" in their approach, or lack of it, to the problems of alcoholism and drug abuse, an American psychiatrist has charged.

"The abuse of these substances is one of the main causes of ill health and trauma, whether that trauma be self-inflicted, victimized or accidental," Dr Abraham Heller told **The Journal** in an interview.

Dr Heller, clinical associate professor at Brown University, Denver, Colorado, was here to address the 1975 New England School of Alcohol Studies.

"One only need think of car accidents, industrial accidents and home accidents, where alcohol is the root cause, as just one phase of the problem.

"Nonetheless, the teaching of alcoholism and drug abuse treatment in United States medical schools is the exception rather than the rule".

He said his own university is seriously involved in its responsibility and students in both psychiatry and public health receive lectures and have clinical training assignments which expose them to the victims of addiction.

However, at one Denver hospital, some 50% of the medical-surgical floor is taken up with alcohol or alcohol-related cases, "often undiagnosed and untreated", he said.

The situation in Canadian medical schools is believed to be little if any better and information is difficult to come by, a situation which Dr Graeme Low, head of the Alcohol Unit at Montreal General Hospital and a lecturer in psychiatry at McGill University, is trying to rectify.

Dr Low is at present attempting to survey medical schools across the country to find out just who does what regarding alcoholism and drug addiction.

Last year, Dr R. F. Patrick Cronin, dean of medicine at McGill, offered Dr Low's unit the opportunity to set up a teaching program in the area of alcoholism and addictions.

"We accepted the challenge and an elective course entitled Alcoholism and Drug Abuse was introduced for first-year students," Dr Low told **The Journal**.

Of 165 first year medical students in the 1974-75 year, 100 registered for the course and were still enthusiastic when it ended, he said.

The course consists of a series of eleven 3-hour weekly presentations.

"Featuring a strong clinical orientation, it exposes the students to the magnitude, consequences, rationale, and management of alcohol and drug abuse victims. We use films, audiovisual presentations, lectures, confrontations with alcohol and drug abusers, and small group discussion," he said.

"In many cases, these students already have certain skills necessary to work with the alcoholics and drug abusers which only need to be supplemented with knowledge of techniques."

Integrity the issue

DETROIT — Dishonesty and "super subconscious programming" are among the larger issues which cause drug abuse and alcoholism, Dick Gregory, former comedian and night-club entertainer, told the Michigan Alcohol and Addiction Association's spring conference.

"If we're going to come out of a bag of integrity, we don't have to come out of a liquor bag," said Mr Gregory.

Gregory, who abandoned his show business career, has become popular as a political activist, speaker and author.

His views on alcoholism are strongly attached to his overall views on American society. Alcoholism for the poor, he said, "is no accident." Other countries do not have such a high incidence of alcoholism among their poor, he claimed.

"You start talking about the politics (of alcohol abuse) and they will wipe you out."

One of the main attractions of alcohol, he said, is that it helps users cover up their insecurities about society. He urged the audience: "Stop playing games with yourselves," and "deal with the system".

Either everyone, including private citizens, begins acting with integrity, "an open and shut issue", or people will still be "playing games with themselves," according to Gregory.

"One day we're going to have to deal with integrity, and the sooner

Dick Gregory

it happens the better. When you relieve the fears and insecurities, funny things happen."

The key to integrity, Gregory maintained, is spiritual. "The day America tightens up her spiritual thing," he said, "is the day you close down the liquor stores."

Cocaine cost limits use

By MARY HAGER

OAKLAND, CAL. — The high price of cocaine is the only block to an explosive growth in its use, according to an epidemiologist with the Haight Ashbury Free Medical Clinic in San Francisco.

Almost everything about cocaine is on the positive side for the counter-culture, Dr John Newmeyer said here.

It is the most positively regarded drug for sexual enhancement; it is considered pleasant, potent and stimulating; and it is regarded as safe and non-addicting, he said.

If importers decided to take a cut in their profits — now about 100 times their purchase price — and increase distribution, the situation is "amenable to growth", he told participants in the Alcohol, Drug Abuse and Mental Health, 1975, Conference at Mills College here.

Work at the clinic has shown that cocaine has caused little damage in regard to overdoses, habituation, or a rise in the crime rate, and that "reasonable, rational people might place it in a category with marijuana".

He said introduction of the coca plant would produce more benign use, since the potential for abuse is much less when the drug is in a natural state, and not a chemical derivative as is the white powder used in the Bay Area.

Butorphanol shows promise

By PETER MICHAELSON

OTTAWA — A new non-narcotic analgesic is showing ever-greater potential as a maintenance drug for narcotic addicts, the International Symposium on Drug Safety was told here recently.

Dr. Bernard Belleau, a researcher with the laboratory of medicinal chemistry at McGill University, said the drug — called butorphanol — will precipitate the abstinence syndrome when administered to morphine addicts, and will not substitute for morphine or heroin in such addicts.

He told more than 200 delegates attending the symposium sponsored by the federal Health Protection Branch that the drug's adddiction liability has also been rated very low (if not nil) by experienced clinicians specializing in narcotic addiction.

In short, it is a potent non-narcotic analgesic virtually devoid of the undesirable side effects associated with the narcotics and several of their known antagonists, he said. It is 100 times more active than morphine as an analgesic.

Dr. Belleau, a former drug company scientist, said the drug is the result of research begun about five years ago by himself and research personnel as Bristol Laboratories of Canada, near Montreal. He said Bristol-Meyers Pharmaceutical Division hopes to begin marketing the drug early next year, but was not certain in what countries it would initially be available.

He said the drug may have an impact on narcotic addiction from another vantage: "It is our hope that this recent medical advance may lessen and perhaps eliminate our dependence on imported opium as a source of legitimate and illicit drugs because butorphanol is a totally synthetic agent."

Clinical results with more than 1,000 patients, most of them in the United States, have established that the effective pain-relieving dose is about one to two milligrams. For very severe pain, a dose of three to four milligrams may be required.

While none of the side effects associated with the narcotics or the "unclean" antagonists have been observed, the drug can cause a slight respiratory depression of about 15%. However, this depression is apparently not increased even at 10 times the effective dose.

Dr. Belleau said preliminary studies show the drug has a mood-lifting effect capable of alleviating depression. He said most of the addicts who volunteered to test the drug have voluntarily come back for continued treatment.

Oxilorphan, another drug with a chemical composition similar to that of butorphanol, was also discovered by the Canadian researchers. This drug does not have the potent analgesic properties of butorphanol; however, it is a long acting and pharmacologically clean narcotic antagonist relative to cyclorphan, a potent antagonist developed in the 1950s, which had undesirable clinical features.

Oxilorphan is also currently under study for the clinical treatment and prevention of addiction to narcotics. It was recently discovered that it induces diuresis in man by reversibly inhibiting the antidiuretic hormone, a novel property which is under investigation.

Dr. Belleau went so far as to say that further improvements along the lines mapped out by the development of butorphanol and oxilorphan "should provide a viable approach to the design of the long sought magic drugs" of which doctors have long dreamed.

'Guilt-ridden' MDs at risk

CALGARY — Doctors are at "an insupportable high risk" of alcohol and drug addiction, suicide and marital breakdown, members of the profession were told at the annual meeting of the Canadian Medical Association.

Dr K. I. Pearce, professor of psychiatry, University of Alberta, said the way they are selected for medical school, the way they are trained there, and the way they practice, lead to guilt, denial and role strain.

He defined role strain as the difference between the role one thinks he is expected to play, and the one he sees himself playing.

Dr Pearce titled his talk Doctors: Drinks, Drugs and Drudgery, and outlined data from the world literature on psychosocial problems of physicians.

In the United States each year, it takes the complete graduating class of an average medical school just to replace the practising doctors who have killed themselves. Women doctors commit suicide twice as often as male ones.

One study estimated that one-third of the time doctors spend in hospital as patients is because of self-medication with drugs or alcohol. Doctor addiction to drugs other than alcohol may be 12 to 100 times higher than in the general population, and an estimated 300 become addicted to meperidine (Demerol) in the US each year.

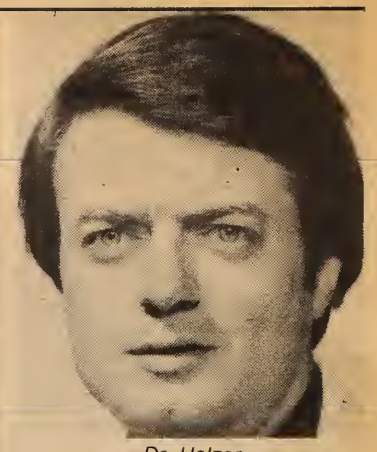
The physician has a different type of addiction, Dr Pearce said.

"His addiction is a solitary one. He is not suported by a sub-culture as other addicts frequently are. He is noted to withdraw from his family.... In those states in the US that have confronted this drug problem, a 92% return to practice has been reported after a program involving five-year compulsory supervisions of practices."

Dr Pearce suggested the problem starts with medical school selection, which is largely based on grades.

"A large proportion of every medical class selected on this basis includes a great number of guilt-ridden over-achievers who are already in difficulty from role strain."

In medical school, the student has as a role model "the faculty member who himself is the most over-achieving of the whole bunch of medical over-achievers," which aggravates and accentuates the personality problems the student had even before entering medical school.



Dr. Helzer

US soldiers home a year stop drug use

DESPITE DRAMATICALLY high levels of narcotic usage and addiction among United States servicemen in Vietnam, "surprisingly" few retained their drug-using behaviours up to a year after returning home.

In fact, use of narcotics among randomly-sampled veterans appears to have fallen even below pre-Vietnam levels, said Dr. John Helzer, psychiatrist at Washington University. Liability to addiction has also reportedly fallen to pre-Vietnam levels.

Reporting on one segment of a series of studies related to drug use before, during, and after Vietnam, Dr. Helzer said results indicated that "in certain circumstances, individuals can use narcotics regularly and even become addicted to them, yet be able to avoid use in other social circumstances."

Data were based on interviews with 451 randomly selected enlisted men and draftees one year after their return home.

Prior to Vietnam, only 2% of the individuals interviewed had ever used heroin, and less than 1% had used a narcotic more than 25 times.

Once in Vietnam, consumption patterns changed dramatically, said Dr. Helzer: Two-thirds of the men reported using marijuana, 43% used narcotics at least once, and 47% of those who tried narcotics became addicted.

"This addict group represented 20% of the entire general sample," said Dr. Helzer.

The survey further indicated that if a man was going to use narcotics, he usually began early in his tour of duty. For example, 20% of all users began within the first week of arrival, and three-fifths within the first two months.

This immediate surge of use, before the serviceman had really gotten into much combat, and before he experienced the trauma of danger and death of friends, suggests that the consequences of war were perhaps not so critical to drug use motivation as originally thought.

The studies showed no correlation between drug use and assignments, danger, or death of friends, Dr Helzer told the American Psychiatric Association annual meeting.

Treatment is 'nil' in prisons

MONT GABRIEL, QUE. — Rehabilitation of drug addicts in the Canadian prison system is almost non-existent.

This was one chief conclusion of a conference here on drug addiction, treatment and the criminal justice system.

As a way around the situation, delegates agreed there should be significant expansion of the number of options to prison, available to decision-makers in the justice system.

The diversionary system evisaged would include specialized residential treatment centres, clinics, and other therapeutic settings.

Such tactics might allow more effective and less costly — in both social and economic terms — approaches to the treatment of addict-offenders.

Some 50 delegates representing the judiciary and penal systems and the drug addiction field, attended the conference organized by the Portage Program of Montreal at the request of Warren Allmand, solicitor general of Canada, and Jerome Choquette, Quebec minister of justice.

According to Stephen Cumas of the National Parole Board: "The criminal justice system as a whole, acts as a centrifugal force which draws into its core more and more addicts.

"Given their medical problems and the lack of appropriate programs, they find it increasingly difficult to extricate themselves from the drug situation.

"When we come to treatment within the walls, with the exception of some work in the West, it is nil, save for some attempts at group therapy.

"And this is quite obviously so. Our security measures, custodial factors, and the very ambiance of the pentientiary, do not lend themselves to therapeutic measures", he said.

From the addict's point of view, the system is a labyrinth, delegates agreed.

If an addict enrols in a therapeutic program prior to serving sentence, prison can and very likely will, undo the therapeutic result.

If he registers in a program after he serves sentence, the program is receiving a more resistant, more difficult, and possibly hopeless case.

This was spelled out by John Devlin, executive director of Portage: "Over the past two years, we have been able to rehabilitate not all but a good percentage of the individuals referred to us before sentencing was passed.

"Unfortunately, we have had much more difficulty with those who have come to us immediately after periods of incarceration. It appears this group regresses or lacks motivation as a result of jail".

Although delegates generally concurred that time at a community-based residential program should be part of the drug-offender's sentence, judges do not at present have this choice.

Delegates also agreed that imprisonment for simple possession of all but narcotics, should be abolished.

As for narcotics, Stephen Cumas of the parole board said: "My own experience with the hard drug user, and that of my colleagues, is that usually he has had a delinquent pattern prior to his use of drugs.

"In other words, he was a member of the criminal subculture and then, through experimentation, he has made drugs a theme of his criminal life.

"In the initial respect, he is not much different from the ordinary offender. It is merely that the complication of his drug addiction makes it infintely more difficult to deal with him.

"It is enough that we have to sort of undo the skeins of a criminal personality but when he also has an addiction, which is a part of his personality too, then we realize how much we need outside help and specialization."

Delegates called for more research into psychological variants in the addict population.

An ex-addict delegate said: "The medical people say 'It is not really a medical problem, it's a social problem'. But the social agencies take the opposite tack.

"So the addict is sloughed off again. I can tell you from my own experience how difficult it is for the addict to get treatment",

It was also suggested that cultural or regional differences in drug abuse patterns should be part of any research undertaken.

Conference proceedings will be available at $10.00 each with papers in English or French as presented, from Portage Program, 3418 Drummond St., Montreal.

Que. supports residential treatment

MONT GABRIEL, QUE. — Cooperation and encouragement will be the hallmark of Quebec's attitude to the concept of community-based residential treatment of addict offenders, according to a justice department official.

The Portage Program was just a beginning and is being used as a pilot study, Maurice Gauthier Quebec's associate deputy minister of justice, told a conference here on drug addiction, treatment and the criminal justice system.

"Two years ago, we had no treatment for the drug addict. Portage is a beginning with respect to residential centres. Its achievements have been beyond our expectations."

He said the department believes it has "a legal duty" to favor such sociomedical rehabilitation of addict-offenders.

In this, it must work with the department of social affairs which has jurisdiction over hospitals and community health centres, he said.

"We have come to the conclusion that the best situation is a special centre where the drug offender will live in a homogenous group.

"Whether he is a minor offender or not, he needs specialized care. The drug-offender has more chance to benefit from the good effects of a program adapted to his special needs."

Problems insuring alcoholics

MILWAUKEE—Three major stumbling blocks have to be overcome before insurance coverage for alcoholics in industry becomes general, according to John Lavino, an insurance executive.

"Firstly, many insurance companies do not offer coverage. Then many industries will not accept the coverage when it is offered.

"Finally, employees and their doctors will not use alcoholism as the diagnosis when submitting employee claims".

Many companies deny they have alcoholics working for them, "others fear there will be rate increases through such coverage, and many organizations just don't care," he said.

Mr. Lavino said at the annual forum of the National Council on Alcoholism here that when his own company, Kemper Insurance, extended coverage to include alcoholism treatment and outpatient centres at no extra cost, "less than 50% of the policyholders accepted the package". Only when representatives went out and explained the policy were some of the fears and prejudices linked with alcoholism overcome.

Tough NY law stands despite opposition

ALBANY, NY — The mandatory life sentence for drug sellers that became law in New York State two years ago has been upheld by the State's highest tribunal, the State Court of Appeals.

At the same time, the provisions of the tough drug law put forward by then Governor (now Vice President) Nelson Rockefeller, have been severely criticized by a law enforcement panel reporting to his successor, Governor Hugh Carey.

In affirming eight life sentences imposed under the Rockefeller law, the Court of Appeals ruled unanimously that the New York legislature which passed the law could reasonably have decided that drug trafficking leads to other violent crimes subject to severe penalties.

"As sellers," the court said, the defendants whose convictions were upheld "cannot disclaim their roles in the scourge of drug distribution. The legislature might reasonably deem the threat posed to society by each of these defendants a grave one indeed."

The seven-judge panel conceded that life imprisonment might not rehabilitate the sellers. But, they said, rehabilitation is only one purpose of criminal penalties.

"Faced with what it found to be a high recidivism rate in drug-related crimes, an inadequate response to less-severe punishment, and an insidiously growing drug abuse problem, the legislature could reasonably shift the emphasis to the other penological purposes, namely isolation and deterrence."

The court cited the epidemiologic state of the drug abuse problem in New York State as in part justifying the harsh penalties. Thus, contrary to the defendants' pleas, the judges said, the penalties under the new law were not irrational. Neither, said the judges, were they "grossly disproportionate or cruel and unusual in the constitutional sense".

Disagreeing with the judges is Governor Carey's Law Enforcement Task Force. It says: "There is an urgent need for legislative action to correct some of the most egregious aspects of the 1973 drug law."

Particularly, the task force wants the life sentence reserved only for the most serious offences, and wants it to be discretionary rather than mandatory because "it should not be imposed save where justice so requires".

As of the end of March, 530 people had been convicted under the mandatory life sentence section of the new law. Three-fourths of them come from New York City.

Governor Carey has endorsed some tempering of the Rockefeller Law, but less than his experts panel recommends.

CHILDREN OF ALCOHOLICS

'Caught in a hidden drama'

CHILDREN OF alcoholics are engaged in a coverup "that makes Watergate pale by comparison", in the experience of Dr Judith Seixas.

They have to take part in a hidden drama where the subject of alcohol is taboo and they cannot talk in the outside world about what is going on inside the home. Confusion on all levels involves every family member.

Dr Seixas, director of education services with the Westchester Council on Alcoholism, White Plains, NY, said children struggle to create boundaries and to determine the parameters of reality so they can mature as people who can give and receive love.

"As the coverup gets more and more complicated and the child grows into teens, he or she develops more and more guilt, more and more shame, and more anger and more fear.

"Eventually the sense of hopelessness and the lack of ability to trust the outside world affect the personality."

Dr Seixas said the usual pattern, when the father is an alcoholic, is that he alternates between love and abuse, cannot keep his promises, does not get home to meals or, if he does, does not eat them.

"He complains and is irritable with the family about their behaviour. I know one man who was furious about his son's smoking, yet he kept on drinking.

"The child is often abused and not respected. He is simply pushed and pulled and shredded."

These children live in emotional isolation, often without friends because they are afraid of bringing them home.

They have trouble trusting adults "and as they can't trust the parents then the trust they would normally have for other adults is watered down. They don't trust teachers or other adults in the community."

They have low frustration, low tolerance, low attention span and low self-esteem. All the while they are belittled by the parents.

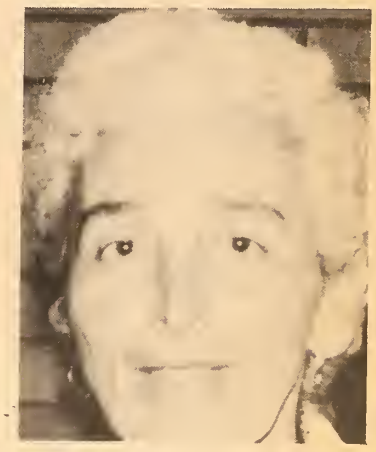
These children have problems in school, often either drop out or run away, and then get into conflict with the law.

"They really don't know where authority comes from or where they are going to, and that is too confusing for them," Dr Seixas said.

She said the child of the alcoholic constantly wonders what he or she has done wrong and how to settle the situation. Often the child uses the non-alcoholic parent as the villan of the piece.

In dealing with these children, "it is important to explain to them that the parents have alcoholism, which is a disease, and it has nothing to do with them. This is one very important reason why it must be viewed as a family illness."

Often, for the sake of stability, as one of her recent cases demonstrated, the children have a wish that the alcoholic parent would stay drunk. This happens even though the children are given a caretaking role that forces them to grow up before they are ready.



Dr Seixas

In this case the mother was the alcoholic and the oldest two of the four children assumed responsibility for the household, including the care of the other two children.

"They made all the decisions, despite the fact they were 12 and 14 years old," Dr Seixas said.

Then the mother would sober up for several weeks and assume command of the household. To compensate for her inadequacies when she drank, she would become overstrict, telling the two girls she would make all the decision, which previously they had been making in a perfectly adequate manner.

"Needless to say, the children were confused and angry and they even hoped to have their mother drunk."

HARVEY McCONNELL reports from a conference on medical aspects of alcoholism sponsored by University of Louisville, Kentucky.

Meds students change attitudes

PLACING ALCOHOLISM and drug abuse in the medical school curriculum can have a dramatic effect on the way future doctors approach the problem.

This is the opinion of Dr Kim Keeley, University of Louisville, and one of the original seven career teachers in substance abuse for medical schools, chosen at the start of a joint program by the National Institute of Alcohol Abuse and Alcoholism and the National Institute of Drug Abuse.

Dr Keeley, who served in that capacity from 1972 to 1974 while at the Medical University of South Carolina, Charleston, is on the review board that chose another 40 career teachers who took up their posts recently.

His course at South Carolina produced a significant increase in cognitive knowledge about alcoholism and drug abuse among the students, Dr Keeley said.

"We tested attitudes at the beginning of the course and they were typical for both most medical students and doctors — very heavily weighted towards the moralistic view. Two years later all of that had dropped and the only way they viewed it was on the sick versus healthy dimensions."

Residents at a family practice clinic also benefited from weekly lectures. Before they began, they identified only 18 out of 2,000 alcoholics. Four months later the figure rose to 38 and three months after that to 58 — still a long way to go but a significant increase.

Dr Keeley said another study he did showed that many of the patients with either psychiatric or drug abuse problems who were brought in dead, had in fact visited the clinic within the preceding six months.

This demonstrated to the medical school faculty that "the boat was being missed on a lot of patients".

Dr Keeley said experience of the original seven teachers has shown that "in the newer medical schools it is much easier for the career teacher to achieve high visibility quickly as there are not special interest groups in the faculty who are more or less in control of resources and curriculum.

"But in well established medical schools, it takes a longer time and a more steady effort."

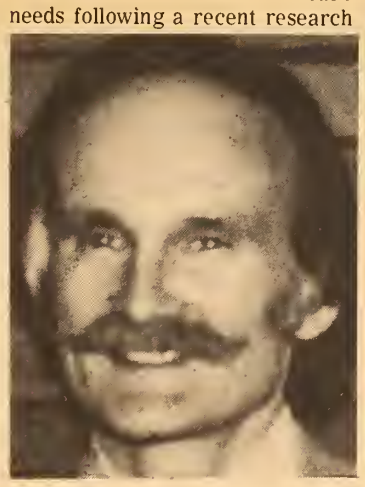
Another major factor is that "it is so easy to say that alcoholism and drug abuse are not medical problems but social problems. I believe that kind of thinking still carries a lot of weight not only in medical schools but in the public at large as well.

Including family therapy

Aggressive intervention needed

AN AGGRESSIVE intervention strategy that includes mandatory family participation is needed for people with signs of early alcoholism, says Dr Kim Keeley, University of Louisville school of medicine.

He bases his ideas on future needs following a recent research study, with Dr Roger Bell, EdD, of stressful life events for 122 patients admitted consecutively in the first year of operation of a general hospital detoxification unit.



Dr Keeley

Researchers used a system developed over the past years in several centres. It measures some 40-50 typical stressful life events. These range from death of a spouse, or divorce, and serious illness, to taking out a loan for less than $10,000.

Dr Keeley, said they found detoxification patients had an average of 3.54 significant life events during the year prior to admission. The control group of 2,029 randomly selected people had an average of 0.12 such events.

There were expected exceptions — about 20% of the alcoholics had stress averages as low as controls and a similar percentage of controls had averages as high as the alcoholics.

Patients who fell into the typical mould were typical of those whose social and economic support systems had deteriorated.

Dr Keeley said introduction of such a measurement system into a detoxification centre can catch these people early.

"They must be treated differently. If you get a detoxification centre that focuses on treatment of late stages of alcoholism, it is going to get a reputation for that and then it can play no role in the prevention of alcoholism."

The system means there can be a tangible measurement and confirms alcoholism is similar to other types of functional syndromes that result from stressful life events.

"I would like to see much more intensive involvement of a patient's family, especially the spouse. If the person comes in for treatment, then the family has to agree to come as well.

"There are some legal problems but I feel if the weight of evidence is going to pile up to suggest the family system has not provided support during stressful life events, then it is obvious something has to be done."

Dr Keeley is realistic in his approach: If the family does not agree he thinks they should be told the patient will be sent to a more custodial type of care.

"Why waste your time when you know the family is not interested? Your chance of success is much less."

Dr Keeley said his strategy involves a vital legal point, the invasion of privacy. And this stymies a lot of doctors when it comes to dealing with alcoholics.

"If a treatment team knows care would be improved if the family was involved, at least they ought to be allowed to go to the family and ask. They could still say no but at least the doctor would not be in the position where he has his hands tied when he knows there is a much better therapy but because of confidentiality he is restricted from delivering it."

Physician--first,know thyself

ALCOHOLISM MUST be considered a direct medical responsibility and physicians must search for early signs and have the courage to tackle patients.

This means, according to Dr Anthony Reading, MD, DSc, Johns Hopkins University, alcoholism should not be singled out as different from other illnesses.

"One approaches the problem from the standpoint of sound medical management."

At the same time, physicians should not be overburdened and become responsible for the entire care of the alcoholic because they will venture into uncharted areas. This should be left to others while the physicians handle the areas in which they have special training.

Dr Reading, director of the alcoholism program and associate professor of both psychiatry and medicine at the university, said that from the medical viewpoint this is not as easy as it may sound.

"If you wait until you are certain a patient has alcoholism you wait maybe longer than is useful for treatment.

"If you start treatment earlier than that, then you may be treating for alcoholism people who are not alcoholic, or label people as alcoholics who may not be on the way to chronic alcoholism.

"There is no generally agreed upon view of the early stages of alcoholism or where the line is through the problem that people cross that separates non-alcoholic drinking from the very early stages of alcoholic drinking."

Dr Reading said physicians in general practice should look back on patients who have become alcoholic and try and see signs they may have given which might help in future identification.

But the physician must be careful "because at that stage people are much more sensitive and there is very little solid evidence you have to confront them with. There is where I think the physician can do a great deal of testing the patient."

Patients look to the doctors for clues as to what it is permissible to talk about. "If a doctor is anxious about getting a sexual history, he will not get one. And if he is anxious about getting a drinking history, he will not get one.

"I do not think physicians can be receptive in the area of alcoholism unless they are receptive in the other areas of human troubles," Dr Reading said.

"The physician needs to be comfortable enough with himself that when the patient broaches any of these subjects he can discuss them."

Dr Reading said that in one way or another the physician ends up with the major responsibility in the field of alcoholism.

"I have a very strong personal belief that as far as alcoholism is concerned it must be regularized and not be something different. As a physician, alcoholism is only a medical problem to me."

Dr Reading

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Roadside screening

LEGISLATION ALLOWING roadside breath screening of suspected drinking drivers (See page 1) should certainly strengthen the powers of highway and traffic patrols.

But whether it does something to reduce alcohol-related fatalities depends on how consistently and forcefully that power is used, and how much backup the police officer gets when the charged driver gets into the courts.

Roadside screening of the type projected by Justice Minister Otto Lang is not a new device. It was tried in Britain in 1967 and it did, initially at least, suppress the numbers of drinking drivers taking to the roads.

In the first year, fatalities dropped a stunning 14.5%, but by the third year that reduction had dwindled to 5.7% and thereafter, the level of fatalities returned to pre-breathalyzer days.

This return to the status quo has been characteristic of most nations where breathalyzer laws — with or without the powers of roadside screening — have been implemented.

It is a rebound that can be expected in Canada as well, unless the commitment to curbing drinking drivers goes beyond the institution of this one legal artifact.

Dr. Robert Borkenstein, the man who developed the breathalyzer, believes the major reason for this failure of sustained effect lies in the spotty nature of enforcement.

Compared to the millions of car trips made by drinking drivers each year in any large city, the number of arrests and convictions is minimal. It is like "catching a new fish from the sea of drunken drivers and making horrible examples of them," says Borkenstein.

Even in Britain, where breathalyzer laws have worked better than in most countries, the individual citizen has come to realize that his chances of being spotted are so slight that the odds are all in his favor.

Unless community leaders are convinced of the need to assign far greater proportions of their police forces to traffic-law enforcement, unless the courts are willing to follow up more diligently on the cases brought before them, and unless the drinking driver can anticipate coming face to face with the law, the effectiveness of the roadside screening device is unlikely to outlive its initial "shock" effect.

Alcohol is as much a part of modern society as is use of the car. It would be folly not to expect some overlap. The implementation of roadside screening should be seen as but one small measure in countering this overlap.

What remains as the most relevant issue goes well beyond the breathalyzer: How willing is society to curtail some of its drinking activities in order to cut back on road deaths?

Teenage drinking

GUELPH, Ont.—Classroom disruptions caused by intoxicated students on the last day of school in previous years have led the Wellington County Board of Education to shorten the length of the final day of high school classes."

—Toronto Globe and Mail (June 11, 1975)

The above news item provides food for thought as to what the future may hold in store.

For example, now that a sizeable number of high school students are drinking regularly at noon hour, perhaps schools will meet the challenge by providing afternoon siesta periods to assist students in the recovery process.

And now that alcohol is beginning to intefere with good, clean fun at school dances, perhaps educators can be expected to set-up in-house bars to facilitate drinking.

Clearly, until the formal school system decides to face and attack the mounting problems created by increased student drinking—particularly during the school day—the future looks pretty bleak.

There are, of course, no easy solutions. But the school system has a clear responsibility to confront and begin tackling the problems created by extensive teenage drinking.

At the present time, it seems schools are adopting a variety of approaches to deal with such presenting problems as students with hangovers, students drinking at lunch hour, school dances and other social and sports events.

Occassionally, the student is sent home for the day, in more severe cases, the student may be suspended. But, more often than not, it seems the problem is totally ignored.

While no solid information seems to be available on whether a strict no-drinking policy is helpful in reducing drinking problems in schools, a punative approach may not be a bad place to start.

In the meantime, schools have a responsibility to begin looking and testing various alcohol education approaches to determine what works in which circumstances. This, for example, will involve testing high and low fear programs.

Little is known about alcohol education. The subject has a long but rather undistinguished history, with much of its origin seeped in abstinence and religious traditions.

More recently, there has been little in the way of alcohol education and it should not be difficult to convince both educators and students of the need for some renewed effort in this area.

Very few young people have benefitted from learning about alcohol. . .objective facts about the drug, its uses and its problems.

There is considerable reason for concern with the special problems created by teenage drinking. Young people are being raised in a drinking society where per capita consumption and alcoholism are increasing hand-in-hand.

"When you said I'd be given a classful of straight A's, I had no idea you meant alcoholics!"

Letters to the Editor

Sir:

According to John Rhodes, Ontario Minister of Transportation and Communications, 23,371 people were convicted for impaired driving and 14,817 were convicted for drunk driving during 1974.

Impaired drivers should be given the same consideration they give their potential victims, which is to say none.

Unless a driver's licence is to be considered a licence to kill, surely these menaces should be permanently taken off the road.

William E. Rae
Scarborough, Ontario

NCAE contract

Sir:

Your March 1 issue had an article "Crunch for NCAE?" which contained some misrepresentations of fact. The article suggests that Dr Irving Wolf was on the NIAAA panel which awarded the contract to URC and then was hired by URC—implying a conflict of interest.

In fact, the Centre contract was awarded in May 1973 to URC after review of proposals by an independent evaluation panel headed by Dr Wolf. NCAE's first director was Mr. Dean Coston. Dr Wolf completed his one year tenure at NIAAA in June 1973 and returned to Boston University as Professor of Psychology.

When Mr. Coston resigned in November 1973, URC sought a Director who was familiar with NCAE and NIAAA and could take over the operations immediately. We discussed the situation with Dr Wolf and in the interest of NCAE's program he agreed to be considered as Director. The appointment of Dr Wolf was reviewed and approved by NIAAA and by the Secretary of HEW. Because of Dr Wolf's involvement in the procurement, the Secretary announced the appointment in the Federal Register.

For your information seven organizations submitted proposals to NIAAA for continued operation of NCAE after March 31, 1975. An independent evaluation panel unanimously selected University Research Corporation to continue operation of the Centre. URC's contract is for approximately $974,000 for one year but has two one-year options for extension.

Gary F. Jonas
President
University Research Corporation
Washington, DC 20015

Quality report

Sir:

The mission of the National Alcoholism Forum held in Milwaukee during April was communicated with sensitivity and quality to the Milwaukee Community.

We take this opportunity to thank you and your reporter, Harvey McConnell, for the time and effort spent in making this happen.

John W. Sell
Executive Director
Milwaukee Council on Alcoholism, Inc.

METHADONE MAINTENANCE has come under increasing fire in the last few years. For example, **The Journal**, July 1, 1975, contains the following headlines: "Methadone: It Only Appears a Failure", "Fertility of Methadone Users is Suspect", "Brain Changes on Methadone are Harmless", "Heroin's Acute/Chronic Effects Differ", and "Methadone Hinders Driving — Slightly".

It is interesting to contemplate the reasons and the sources for this not so subtle attack — an attack which recent issues of **The Journal** have made increasingly apparent.

Of course, I assume this does not represent a campaign on the part of **The Journal**. But what of the drug abuse industry, the medical and professional community at large, or our national political entities?

Why, you may wonder, do we ask these questions? Undoubtedly since before the beginning of the more recent approaches to the treatment of narcotic addiction, the lines were drawn, the battle formations ordered.

In a hypocritically puritanical society, drug freedom is clearly devoutly to be required for the other guy. One also hears

Backgrounder

By MILAN KORCOK

Cannabis legislation on the move

LEGISLATIVE ACTIVITY decriminalizing marijuana use continues to gather momentum throughout North America.

With California's passage of the Moscone bill, the most populous state in the United States becomes the fifth to end the arrest and jailing of people charged with possession of small amounts of marijuana.

This summer, Alaska, Maine, and Colorado have also enacted legislation modelled after the successful civil fine law in effect in Oregon since 1973.

In Canada, the Senate Committee on Legal and Constitutional Affairs has ended its hearings on the proposed government bill allowing first offence for simple cannabis possession to be punishable only by fine.

In its own recommendations, the Senate Committee went well beyond government proposals by urging amendments that would ensure automatic pardons be granted all people found guilty of a first offence for possession. The committee also recommended that such people be given an absolute or conditional discharge in place of a formal conviction.

Though it is still uncertain how the cannabis bill and the Senate's recommendations will fare in the House debate, Health Minister Marc Lalonde is said to have told certain groups he would not oppose decriminalization. The opposition that is expected will likely be mounted by backbenchers.

The use of the "citation" approach to punishing marijuana users is obviously gaining appeal as the most reasonable compromise for those who want to lessen the legal impact of personal marijuana use while still retaining some deterrent controls.

The California action calls for a maximum $100 fine for possessing no more than one ounce of marijuana. Enforcement would be via citation rather than arrest. Misdemeanor penalties will apply to possession of more than one ounce. The new law will take effect in California January 1, 1976.

The Colorado bill, approved in June, calls for the same $100 maximum fine for "non-public" possession of up to one ounce. Public display or consumption also carries a $100 fine, but the offender is still subject to arrest and possible jail term of up to 15 days. The new Colorado law took effect July 1.

The new law in the state of Maine, which will take effect March 1, 1976, calls for a maximum civil fine of not more than $200 for possessing up to one and a half ounces of marijuana, with a traffic-type citation replacing arrest.

The changes in the Alaska law, to take effect in September, also stipulate the maximum $100 fine for personal possession, but ensure that under the new measure, arrests, arrest records, and jail sentences would be eliminated.

The legislation also specifies that smoking marijuana in public, or driving a car while in possession of marijuana, will be punishable as a misdemeanor offence — criminal classification — with a maximum $1,000 fine, but with the possibility of jail sentence removed.

Similar proposals to decriminalize possession of small amounts of marijuana are now being considered by the US Congress, and by several other jursidictions among them Ohio, Minnesota, Hawaii, New York, and the District of Columbia.

Still, the trend does not go as far as many reformers would like. In Illinois and South Carolina, legislatures defeated decriminalization bills this year. And Nevada, Vermont, and Wyoming tightened up their laws somewhat.

Should the decriminalization model be adopted extensively, the effect on arrest statistics should be dramatic.

In Canada, the Federal Bureau of Dangerous Drugs says 95% of the 30,000 narcotic drug convictions in 1974 were related to cannabis, and 94% of these cannabis convictions were for simple possession.

In the US in 1973, 93% of marijuana law violations were for simple, personal use, usually of small amounts.

Within this trend to decriminalization, not only legislators but the courts are carving out some interesting precedents. One of the most significant of these may turn out to be the Alaska Supreme Court ruling of May 27, 1975, stating that possession of marijuana by adults at home for personal use is constitutionally protected by the Right of Privacy.

The case arose when Irwin Ravin, an Anchorage attorney, was arrested and charged with possession of marijuana in December, 1972.

Ravin's attorneys filed a motion to dismiss the charges before trial, arguing that the Alaskan statute which prohibits possession of marijuana was unconstitutional because it violates the right of privacy in both the federal and the Alaskan constitutions.

The district court denied the motion to dismiss, but an appeal taken by the Alaskan Superior Court upheld the motion and in the course of doing so articulated arguments that might have some major implications for other jurisdictions as well.

Peter H. Meyers, legal counsel for the National Organization for the Reform of Marijuana Laws (NORML), emphasized to **The Journal** that this action by the Alaska court was the first state supreme court decision to recognize that possession and use of marijuana is entitled to constitutional protection.

The court stated, says Mr. Meyers, that there was "no firm evidence" that marijuana use was harmful to the user or to society, and that "mere scientific doubts" cannot justify government intrusion into the privacy of the home.

The supreme court's opinion, written by Chief Justice Rabinowitz, stated that the "authority of the state to exert control over the individual extends only to activities of the individual which affect others or the public at large as it relates to matters of public health or safety . . . .

"The right of the individual to do as he pleases is not absolute, of course. . . . It is conceivable, for example, that a drug could so seriously develop in its user a withdrawal or amotivational syndrome, that widespread use of the drug could significantly debilitate the fabric of our society.

"But we do not find that such a situation exists today regarding marijuana. It appears that effects of marijuana on the individual are not serious enough to justify widespread concern, at least as compared with the far more dangerous effects of alcohol, barbiturates, and amphetamines."

How will the Alaska Court action affect others?

Meyers is optimistic: "The Ravin decision signals the beginning of a new era in marijuana litigation. A state supreme court has recognized that marijuana possession and use is entitled to constitutional protection.

"We can now expect other state and federal courts to give these constitutional issues serious examination.

By Wayne Howell

THE SOUTH Pacific island of Aku-Aku was a tropical paradise until the natives accidentally discovered how to ferment the fruit of the ju-ju tree to make 'jui-hi', a potable beverage of most amazing properties.

The natives took to their new discovery with relish and in a matter of years King Tibi-Tibi had a major jui-hi problem on his hands. The dismayed king took his problem to 'man who sleeps with our wives', which was the name the unsophisticated islanders had given the anthropologist from the University of Toronto.

"Your society is based on indolence and inanition, tradition and tabu," said the anthropologist. "Your people have a past but no future. No wonder they fritter away their time in a jui-hi stupor.

"You must create a society where the individual can achieve; where he has the freedom to be whatever he wants to be; where he can do whatever he wants to do — or can get away with. Then your people will turn away from jui-hi and develop their own potential."

That made sense to the king. So he set up a real estate board, started a commodities futures market in breadfruit, and had US army engineers relay the Dow-Jones averages from Guam, via satellite.

Momentous changes took place. But the jui-hi problem stayed about the same; some said it was getting worse. And so the king went to see "man who sleeps with our daughters", which was the name the simple islanders had given the anthropologist from Harvard.

"Your society is based on cut-throat competition; there are too few winners and far too many losers who have lost out in the Darwinian dance for supremacy and have taken to jui-hi for solace and comfort," said the anthropologist from Harvard.

"You must create a more humane society and instil in your people a sense of social purpose. Then they will turn their backs on jui-hi and work for the common good."

That made sense to the king and so he sacked the banana barons, confiscated the coconut conglomerates, purged the papaya proprietors, collectivized the labour force, and filled the workers' minds with catchy slogans and pious platitudes. But the jui-hi problem stayed about the same; some said it was getting worse.

And so the king went to see "man who sleeps with our sons", which was the name the natives had given to the anthropologist from Oxford.

"You must create a society where man is unencumbered by the artificial values of civilization, where he is free to live as Rousseau intended him to live, where he is free to live as he chooses but where he knows his place in the great scheme of things."

"This is where I came in!", exclaimed the king.

He had nothing to lose, and so he sacked the social planners, packed in the propagandists, banished the bureaucrats, and encouraged his people to go back to waiting for the coconuts to drop from the trees. But the jui-hi problem stayed about the same; some said it was getting worse.

Guest Book

Jordan Scher

regularly from the ranks of the abstinence-sayers, that the only treatment for addiction is abstinence.

It seems of little consequence to them that exceedingly few addicts either will, or can, tolerate or accept the required program of total abstinence in a seclusive and oppressive retraining situation for an extended period of time. The number of those addicts who will accept such a rigorous and self-effacing commitment is very few, and the number of those who can stick it out, far fewer still.

From another quarter, hostility to a drug-oriented treatment approach such as methadone is even more de rigueur. I refer to those reactionary police and enforcement groups who see their role as one of harassing all addicts out of existence by hook or by crook.

For many such agents provocateurs, enlightened by a 14th century inquisitional philosophy of witch-hunting and witch-burning, the only good, or reformed, addict is a dead addict. Doubtless some of them still yearn for the simpler times when an auto da fe could solve the problems of those infected with an insufficient degree of adherence to, and acceptance of, the true faith, whatever it might currently proclaim to be.

Another source of aggravated hostility toward the methadone treatment of addicts is what I call the pusher — or heroin — lobby. This is an informal, but highly coherent, and extremely effective street addict conventional wisdom or unwisdom. Whatever its source, or sources, every street addict is taught at his pusher's knee, or needle, to be terrified of, and to eschew that dreadful and dangerous stuff called methadone.

Among the methadone myths which the pusher promulgates are such calumnies as claims that methadone gets in your bones, is harder to kick than heroin, damages mothers-to-be and unborn children, causes your teeth to fall out, causes cancer, and God knows what other cheap, phony, and unsupported denigrations.

The Blacks and other minority groups have a special variation on this theme and talk about, or imply, personal degradation, racial enslavement, and genocide, as well.

What the pusher and his unfortunate dupes do not remember is that the true alternative to methadone is not abstinence, but *street addiction to heroin*. As everyone should know, heroin is the real source of degradation, potential and actual physical illness, involvement in the horrors of street hustling, serious and long term involvement with the law, and the ultimate and inevitable possibility of death. This lovely picture of the beauties of street addiction somehow escapes the notice of the abstinence-sayers, the enforcement proclaimers, the pusher lobby, or the minority lobby.

It was even more disturbing to me recently, to hear a professional echo the street junkie claim that a patient should "get off methadone fast, so that he will not get a habit on methadone, as well as one on heroin". As if there were any difference between addiction to one narcotic and addiction to another. This is of course another pusher distortion which finds it way occasionally into the naive and too accepting mind of even the presumably experienced professional.

As the "Methadone Appears a Failure" article in **The Journal** notes, at its peak "only about 10% of the country's addicts were in treatment".

This statement clearly gives the lie to any possibility of a meaningful evaluation of the use of methadone in the treatment of addiction.

If one judges from the available putative addiction statistics, quite likely less than one quarter of all addicts have been in treatment. In fact, it is more likely that less than 10% have been seen in clinics.

It becomes next to impossible then to make any statement about how effective methadone is or is not in the treatment of street addiction. Furthermore, the exceedingly wide spectrum of performance, expectation, and effectiveness among the various methadone treatment programs, permits only a very inadequate judgement of their accomplishments or failures.

And when we come to the articles concerning fertility, brain changes, driving, etc., one sees evidence that the so-called scientific community is subtly reinforcing the great unwashed's antagonism to methadone.

Every one knows it has become politically convenient to decry the effectiveness of drug treatment, especially that of methadone for narcotic addicts. In fact, so potent have the fads and vagaries of the political winds of change become that we have now swung full force into the newest potential scam and boondoggle, "the war on alcoholism".

Not having curbed addiction, anymore than we won the Viet Nam war, many politicians would have us sweep these lick and promise "failures" under the rug and march on to attack alcoholism full force. Now we will cure alcoholism, they proclaim, as we have cured drug abuse!

Such delusions are pathetic, unrealistic, and destructive. We must be prepared for the long pull, the constant demand to chip away at the problem of addiction with any and all means at our disposal. It has not gone away. It will not go away.

Addiction will require continuing and mounting efforts, not a foreclosure of effort, if we are to make a serious dent in it. And if we will denigrate, and possibly throw away, the only modality of addiction treatment that has shown serious promise for large numbers, we will have done ourselves, and our potential patients, the greatest of disservices.

Dr Jordan Scher is executive director of the National Council on Drug Abuse and the Methadone Maintenance Institute

Withdrawal is 'conditioned' in addicts

CONDITIONED RESPONSES of the type that may prompt detoxified addicts to resume their old habits can be produced in humans in a laboratory setting.

Such conditioning has previously been demonstrated in laboratory animals, but the only evidence thus far in humans has been anecdotal.

Working with eight volunteers, all addicts in a methadone program, Dr Charles O'Brien and colleagues at the University of Pennsylvania conditioned subjects so that environmental cues—a tone and a whiff of peppermint odor—would set off withdrawal symptoms.

Similar cues have been cited as the reason why former addicts rush back to heroin as soon as they are released from prison, for instance, even though they have been off drugs for months or years.

"We can now say with some confidence that classical conditioning of abstinence phenomena does exist, and that it may be possible to use it to treat addicts," Dr O'Brien said. Once an addict's responses are evoked, he can be taught methods other than drug-taking to cope with them. Gradually the response will be "extinguished".

Dr O'Brien expects conditioning will prove a useful adjunct to classic therapy.

"Until now we have been ignoring many of the behavioral aspects of addiction, while concentrating on the psychological factors," he asserted.

"We suggest that you can enhance treatment by finding out what drug-related stimuli a person responds to, then using behavior therapy to extinguish the response, so that when we finally send the person back to his community, he won't be overwhelmed by his conditioned responses."

In the Philadelphia study, the eight volunteers, all men between 25 and 43 years of age, went through three types of trials—one to establish baseline data, a second to condition the subject, and the third to test the effect of the conditioning.

Each patient was asked to evaluate his own response. In addition an objective observer judged his reaction. Each patient was also tested for skill in performing a pursuit rotor task, and a variety of physiological variables were measured.

In the first phase of the study each of the eight was given a low dose of the narcotic antagonist, naloxone (0.05 mg to 2.0 mg) to produce mild withdrawal symptoms—teary eyes, runny nose, yawning, goose bumps and a decrease in skin temperature. Sometimes the naloxone also provoked nausea, stomach cramps and other subjective effects. These lasted between 15 and 30 minutes.

In a series of conditioning trials (between six and 11 each), the naloxone injections were paired with an auditory tone and the odor of peppermint.

Finally, the auditory and olfactory clues were presented, but saline injections were substituted for the naloxone.

Five of the eight subjects showed signs of having developed what Dr O'Brien and his colleagues believe to be conditioned abstinence: An injection of saline combined with the tone and peppermint odor produced yawning, tearing, rhinorrhea, and "narcotic withdrawal sickness". Even when the data from the three subjects who did not show conditioning are incorporated, the changes over the baseline data are significant, Dr O'Brien said.

—LWS

Five-step program 'leads to abstinence'

A FIVE-STEP program to take the heroin addict from addiction to abstinence was proposed at the meeting.

The program was outlined by Dr. Avram Goldstein, professor of pharmacology, Stanford University School of Medicine, Palo Alto, California, and an authority on both clinical and research aspects of drug addiction.

The purpose of the program, he told the conference, "is to meet the addict 'where he's at' and lead him progressively through a structured set of improvements".

Dr. Goldstein calls his treatment system by the acronym STEPS — Sequential Transitions Employing Pharmacologic Supports.

The first step — not yet practical in the US — is to give the addict heroin injections in the clinic for a limited period at limited dosages. This, Dr. Goldstein said, is safer, more socially acceptable, and less dangerous to society than widespread use of illicit heroin on the street.

Dr. Goldstein's approach is the basic premise of the so-called British system. But it is not treatment, he said, "it is merely the first step to bringing the addict into treatment on his own terms".

The second step involves giving methadone daily by mouth, also at a clinic. This breaks down the "needle habit", Dr. Goldstein said, and while the addict doesn't get as "high" as he would on heroin, it is sufficiently rewarding to encourage daily attendance. This gives an opportunity for general counselling aimed at restructuring the addict's lifestyle.

The third step is to use a relatively new drug, long acting methadone, also by mouth, three times a week. LAAM, as it is called, is a synthetic analgesic similar to morphine or methadone in action, but its effect lasts up to three times as long. It produces even less intensive subjective narcotic effects than ordinary methadone.

Counselling efforts are now stepped up. Explicit motivation for later reliance on a narcotic antagonist is also encouraged at this

CHARLES MARWICK and LYDIA WOODS SCHINDLER report from the 37th annual scientific meeting, Committee on Problems of Drug Dependence, Washington, DC

stage, Dr. Goldstein pointed out. Without this motivation an antagonist can never be completely successful.

The fourth step starts the client on an antagonist such as naltrexone.

The fifth and final step brings the former addict to independence from opiates. However, the clinic staff remain on call for assistance with problems if they arise.

"Relapse to heroin, at this or any other prior stage, need not be counted a failure," Dr. Goldstein said. "Provided the client remains within the therapeutic milieu, the damage can be contained and the stepwise program resumed again."

Dr. Goldstein defended methadone programs against critics.

- Hard-core addicts who previously had failed to remain abstinent after detoxification, succeed in drastically reducing or entirely stopping heroin while on methadone.
- There is a reduction in crime as measured by arrest and imprisonment rates and by direct interviews among those addicts treated with heroin. This is probably a consequence of their reduced need for heroin, Dr. Goldstein said.
- In some programs, addicts on methadone make significant progress in social rehabilitation as measured by employment,

Dr Goldstein

schooling, successful home-making, abandonment of prostitution, etc.

"In times of high unemployment it is a considerable tribute to program staff if any progress can be made with these generally unskilled, uneducated clients. It is no surprise that sometimes no improvement can be shown. One is reminded of the elephant who played the piano: It's not surprising that he played it badly, what's amazing is that he played it at all."

The most significant accomplishment of methadone treatment, in Dr. Goldstein's opinion, has been its role in making narcotic addiction a proper concern of the health professions and making legitimate a more human approach to the victims of heroin addiction.

—CM

LAAM/methadone: equally effective, patterns differ

RESULTS OF a 14-week study involving 193 individuals and comparing the use of the new analogue of methadone, methadyl acetate or LAAM, with methadone itself, have shown the agents are equally effective in terms of controlling illicit drug use, attendance at clinic, and continuation in a therapeutic program.

The advantage of LAAM is that it suppresses withdrawal symptoms for up to 75 hours — three times longer than methadone. This means an addict has to attend the clinic only three times a week instead of daily.

Earlier, double-blind studies with the new agent had shown that LAAM and methadone were equivalent in rehabilitative efficacy. However, such studies cannot evaluate the possible significance of attending a clinic only three times weekly, Dr. Walter Dorus of the department of psychiatry, University of Chicago, told the meeting.

The Chicago study was designed to determine whether LAAM and methadone were equivalent in rehabilitative efficacy even when those participating in the study knew what drug they were taking.

Will the progress of therapy suffer if a patient's drug orientation is diminished? Is it therapeutically important for a patient to spend time and effort to come into contact with a clinic? Dr. Dorus said these questions may only be answered by testing the two agents in a normal clinic setting.

Ninety-seven individuals received methadone, 96 received LAAM. The findings indicate that for the 14-week period the two agents were used they seemed to have the same rehabilitative efficacy, Dr. Dorus said. This is maintained despite the fact the methadone users had to spend much more time in the clinic than the LAAM patients.

But, said Dr. Dorus, while results are the same, patterns and dynamics between the two agents are different. Heroin use decreases with time for the LAAM group but remains constant for the methadone group. Twenty patients on methadone dropped out as compared with 36 on LAAM.

Three factors operate to influence these findings in Dr. Dorus' view. Firstly, the initial doses of LAAM may have been too low, secondly, patients always are anxious when they know they are receiving an experimental drug; and, thirdly, tolerance for staying in treatment at a particular clinic decreases with time.

"We feel dose equivalence between LAAM and methadone is not well understood," Dr. Dorus said.

—CM

Significant advance in nefopam?

ONE OF the first clinical studies to be reported with a new, chemically distinct synthetic analgesic agent, nefopam hydrochloride, shows it acts in a similar manner to morphine, both in its analgesic properties and in the incidence of adverse reactions.

In addition, separate studies have shown that nefopam may not be as subject to abuse or habituation as morphine.

Findings comparing the analgesic effect of nefopam with morphine were reported by Dr. Abraham Sunshine, attending physician at the Arthur C. Logan Memorial Hospital in New York. Dr. Sunshine is also assistant professor of clinical medicine at the New York University Medical Center.

Dr. Sunshine compared morphine and nefopam in 74 patients who required a pain-killing drug by injection for moderate to severe post-operative pain. The results demonstrated that nefopam had a time/effect curve similar to that of morphine. Ten milligrams of the drug are almost as effective in relieving pain as six milligrams of morphine, Dr. Sunshine said.

He added: "There is evidence to show that nefopam is also effective orally. We are currently conducting studies involving the use of oral nefopam and comparing it with standard oral analgesic drugs."

Incidence of adverse reactions did not differ between morphine and nefopam, Dr. Sunshine said, although this is a small group of patients. There were no side-effects reported by the patients or observed by the attending physicians and no patients were dropped from the study because of untoward reactions. Nevertheless, a larger study group is needed to evaluate this point more fully, Dr. Sunshine said.

"If these properties are confirmed in man, and I emphasize the 'if'," Dr. Sunshine said, "it is likely nefopam will prove to be a significant advance."

—CM

INFANT-ADDICTS: NURSES CAN SPOT THEM

A PHILADELPHIA pediatrician has developed an abstinence scoring system for newborn infants born to drug-addicted mothers or mothers on methadone.

It enables the nursing staff to spot accurately those infants who are experiencing withdrawal symptoms, and to what extent, thus making it possible to tailor drug therapy more precisely.

Dr. Loretta P. Finnegan, director of nurseries at Philadelphia General Hospital, described the scoring system and reported a comparative study indicating its clinical practicality and usefulness. Dr. Finnegan is also assistant professor of pediatrics, University of Pennsylvania School of Medicine in Philadelphia.

The scoring system involves 32 different signs and symptoms of withdrawal each of which is assigned a weighted score. For example, an infant who has a continuous high-pitched cry is assigned a score of three. Likewise a score of three is assigned to an infant who sleeps for less than one hour after it is fed.

The neonate is scored every hour for the first 24 hours of life, every two hours in the next 24 hours, and every four hours after 48 hours of life.

When the score amounts to a total of eight points, treatment is started. This is related to the total score. For example if the infant scores between 8 and 10 points, three milligrams of phenobarbital per pound of body weight is given daily in three divided doses. If the score is 17 or above, then the dose is six milligrams.

Thus, Dr. Finnegan noted, the score enables the nurse to monitor the drug dependent infant comprehensively and permits objective clinical estimates of the withdrawal syndrome and the infant's response to treatment.

Evaluating this system, Dr. Finnegan did a study of 38 infants born to heroin-addicted mothers, diagnosed and treated for narcotic withdrawal, compared with a similar group of 38 infants in whom withdrawal was regulated by traditional clinical methods and without the use of the scoring system. There were better levels of central nervous system arousal and improved sucking performance in the study group as compared to the controls, Dr. Finnegan reported.

The Philadelphia Hospital group had previously shown that passively drug-dependent infants have difficulty with the sucking reflex. There is a reduction in sucking rate, pressure, and amounts consumed in infants born of drug-dependent mothers.

Dr. Finnegan said that where the drug-dependent mother has had pre-natal care, the infant is generally heavier and the withdrawal symptoms tend to be more mild or only moderate in severity, than in infants whose mothers have not had pre-natal care. Their infants are lighter in weight and have more severe and protracted symptoms of withdrawal. There is also a decreased incidence of morbidity and mortality in infants whose mothers received pre-natal care.

This holds true whether the woman is on heroin or methadone. The improvement is due to their receiving pre-natal care, not to the type of drug they are on.

Overall, it seems infants of drug-dependent mothers do as well as normal infants as regards neurological outcome as well as developmental assessment by the Gesell schedule. However, there does seem to be some difference in heights and weights.

—CM

Around the world

Polish anti-alcoholism congress provides 'unprecedented statistical insight'

HIGHLAND FLINGS

The amount of alcohol being drunk by young women is "frightening" a Scottish conference on Alcohol and Young People was told. Alan Finlayson said girls look more mature than boys and can get away with under-age drinking more easily. The conference was sponsored by the Scottish Council for Health Education, the Scottish Council on Alcoholism, and the Scottish Licensed Trade Association.

VATICAN RULE

The Vatican has granted permission for alcoholic priests to use grape juice instead of wine when they celebrate Mass, according to the UK journal, Alliance News.

AD COSTS

British tobacco companies spent about $40 million on cigarette advertising in 1974. Sir John Partridge, chairman of the Imperial Group of companies said 27% of that was used to promote brands in the two lowest tar groups in the government's tar and nicotine tables.

By JOHN DORNBERG

MUNICH — Poland, a country of 34 million people, has two million alcoholics.

Fifty percent of all its crimes and 70% of its serious offences are committed while under the influence of alcohol.

Alcohol abuse on the part of one spouse or another is the primary contributing factor in 85% of all Polish divorces.

These and a host of other statistics were disclosed in early June in conjunction with the Third Congress of the Polish Anti-alcoholism Committee, held in Warsaw.

The Committee, established in 1964, is a member of the International Anti-alcoholism Union and is quasi-governmental in structure and support. It publishes a scientific monthly, *Problemy Alkoholizmu* (Problems of Alcoholism) and a more popular journal, *Zdrowie i Trzezowsc* (Health and Sobriety).

Its newly elected chairman is Kazimierz Kuwaka, 54, a deputy attorney-general.

Papers delivered at the congress, and articles published in Polish magazines and newspapers in conjunction with it, have provided Western observers with an unprecedented statistical insight into the Polish alcohol abuse problem as well as a glimpse of the government's rather desultory attempts to come to grips with it.

Thus, according to one report in *Zolnierz Wolnosci*, the Polish defence ministry daily newspaper which covered the congress in considerable detail, "alcoholic intoxication" is the cause for 11% of the absenteeism in Polish industry and for 18% of all industrial accidents.

Although the "statistical Pole," that is every man, woman and child, drinks less than the "statistical West German"—6.4 litres of pure alcohol per capita compared to 14 litres annually—the rate among Polish males aged 18 to 60 is one of the highest in the world: 15 litres per capita.

Consumption of high-proof spirits, according to the latest edition of the Polish *Statistical Yearbook* has increased by 60% in the past decade, whereas, according to Polish sources, consumption has remained reasonably static "in most Western countries".

As in other Communist countries, price increases seem to have no dampening effect on alcohol consumption, largely because wages have risen much more markedly and quickly than the supply of consumer durables or industry's capability of producing them.

In 1970, for example, the average Pole spent 38.5% of his income on food and 8.7% on alcoholic beverages. In 1973 (statistics for 1974 are not yet available) the amount spent on food had decreased to 35.7% while that for alcohol had risen to 9.2%.

The disproportion for 1974 is expected to be even greater because of a 25% increase in the price of vodka and other spirits in January of that year.

Although the Warsaw anti-alcoholism congress called for more effective implementation of existing regulations and a new drive to fight alcohol consumption and abuse, the battle is being waged with only half-hearted governmental support.

Indeed, one could say governmental policy contradicts the aim of the Anti-alcoholism Committee. For the production of alcoholic beverages, of which the state is the sole manufacturer, is a vital item in the national budget.

Thus, while there is nationwide propaganda designed to reduce alcohol consumption, retail shop managers are repeatedly admonished by the State Alcohol Monopoly not to let their sales drop. On the contrary, they are encouraged to boost them with the promise of premiums and bonuses.

One such case, concerning a circular letter sent to a number of village co-op shops, was reported in early June by *Trybuna Ludu*, the official Polish Communist party daily.

The paper admitted that while anti-alcohol propaganda is being cranked up on the one hand, sales officials of the spirits monopoly are "energetically vetoing any decrease in deliveries".

Another problem appears to be the state of permanent chaos in the various institutions charged with conducting the anti-alcohol drive. Funds allotted to them are not used fully and there seems to be no check on their distribution.

According to a recent article in the Warsaw weekly *Polityka*, a national Anti-alcoholism Fund of 175 million zlotys (approximately $9 million) was set up in January 1973 by decree of the council of ministers.

It has been divided as follows: 8 million zlotys to the research-oriented Institute for Alcohology and Drugs in Warsaw, which thus far has spent only half the money "because of organizational difficulties"; 14 million to the Anti-alcoholism Committee for propaganda and its own research institute, of which 12 millions have been used; and more than 150 million to district and area councils for "field work".

These local councils are supposed to use the funds for helping families of alcoholics, organizing lectures, setting up "sobering-up stations" and equipping hospital wards for drying out treatment.

Of the 40 sobering-up stations planned for construction by the start of 1976, only three have been built. All nine planned modern alcoholic wards still exist only on paper and there is, according to *Polytika*, "hardly any hope" construction will start before next year.

Most of the allocated money is being spent on what the journal called "antiquated and boring lectures," useless propaganda, and projects only remotely related to the problem.

Helsinki meeting

Laborers are 'most visible' alcoholics

By JEAN McCANN

HELSINKI — The general laborer appears several times more likely to be one of the alcoholics in a hospital on a given day than is a store clerk, an executive, a bus driver or an electrician.

That is the finding of a survey of about one-third of this country's hospitals to determine the strain on health services caused by the use of alcohol. Other occupations at risk are painters, sailors, lumbermen, construction workers, waiters, writers, artists, shopkeepers and merchants.

Dr Aarno Salaspuro of The Finnish Foundation for Alcoholic Studies, told an international meeting here that the general laborer had more than 7,000 patient-days accounted to him per 1,000 population.

However, "it may be that the social damage due to the use of alcohol is more easily seen in this group than the others," Dr. Salaspuro told the International Institute on the Prevention and Treatment of Alcoholism.

In the executive group, on the other hand, it may be hidden.

Painters were the second-highest risk group, he said, with about 2,300 patient-days. Their risk may be high because "they have been in continuous contact with industrial solvents which give off toxic vapours. This may increase the damage caused by the use of alcohol."

He did not speculate on the reasons for the high risk in the other occupational groups, whose risk ranged from some 1,300 to 1,900 patient-days per 1,000 population.

However, he said, "the results of the survey dealing with other high-risk occupations such as waiters, sailors, artists and writers, show a similarity when compared to ratios of death due to liver cirrhosis."

Approaching the statistics another way, he said, those at high risk of being alcoholics in the hospital were those with various mental and emotional disturbances.

For example, he said, "the proportion of the alcohol patient-days of divorced people is 30 times as large as that of married people, and 15 times as large as that of single people in the hospital group.

"On the basis of marital status, it is seen on the one hand that the use of alcohol is connected with disorders in human relations, and on the other hand, that these disorders may lead to a greater use of alcohol."

The most common diagnosis in the group of alcoholic patients was alcoholism, but other mental disorders were commonly listed.

"In the male group, schizophrenia and other psychoses were more common than neuroses and psychopathic conditions. Amongst females, neuroses were even more frequent than alcoholism."

All together, he said, mental diseases, tuberculosis and accidents accounted for 65% of the diagnoses of the male group, and for 72% of the females.

He concluded: "The main strain placed by alcohol on the public health service is mainly concerned with the various mental disorders, which in turn are caused either by the excessive use of alcohol, or may be a strong reason for drinking. Also, accidents involving drinking are seen to be an important strain on health services.

"But liver diseases due to the use of alcohol do not put so large a strain in Finland as in other countries where the consumption of alcohol is greater."

More data called for

HELSINKI — Alcohol programs in industry may be the most important of all treatment efforts in the long run, because "in any given community the work force may represent a large percentage of the population".

This was one of the major conclusions at the closing session here of the International Institute on the Prevention and Treatment of Alcoholism.

Other major conclusions from the working groups on various subjects and from special symposia:

- More accurate international statistical data is urgently needed.
- The nature and goals of treatment cannot be divorced from their cultural settings. An approach good in one country will not work in another. Also, "it is clear we must tailor treatment to the need of the individual, and avoid offering a single facility for the alcoholic to accept or reject".
- International control of alcohol advertising is required. This is a problem in France, for example, which receives radio promotion of alcohol through programs beamed from Luxembourg.
- More education about alcohol is needed in schools, and medical centres.
- Social workers need to be more involved in earlier identification of alcoholics, and in prevention. They need also to be "involved in community mobilization and action so that environmental and social problems can be removed".
- Much more knowledge is needed about women and alcoholism, particularly studies of the epidemiology, statistics, biochemistry, psychology and sociology of female alcoholism. Means of reaching the female problem drinker must also be further researched.

Smoking chief culprit in heart disease

By JEAN McCANN

GOTHENBURG, SWEDEN — If men who have had heart attacks would simply quit smoking, they could increase their chances of living by 25%.

Stopping smoking is more important than controlling blood lipids by diet or even controlling high blood pressure, according to a Swedish cardiologist who has conducted large-scale epidemiological studies of 30,000 men at risk of coronary heart disease.

"I think we have by and large confirmed many American studies which show that high blood pressure, high blood lipids, and cigarette smoking are of importance" in the death rate after myocardial infarction, Dr. Lars Werko said in an interview here.

However, "in contrast to American studies, we believe cigarette smoking is more important than high lipids, or even high blood pressure", said Dr. Werko, chairman of the department of medicine at Sahlgrenska hospital here, and dean of the medical school at the University of Gothenburg.

"In a study we did on patients who had myocardial infarctions, where we compared those who stopped smoking with those who did not stop smoking, we found that the mortality experience was reduced by 20% to 25% in those who stopped, even though they had larger areas of myocardial infarction."

In a heart attack prevention trial involving 10,000 men in a treatment group, and two control groups totaling 20,000, Dr. Werko and his colleagues have achieved a 50% success rate in getting men to quit smoking. All men who smoke more than about 15 cigarettes daily were invited to a special antismoking clinic.

Under direction of a medical doctor and psychologist, small group meetings were held to explain the dangers of smoking and to encourage the smokers to quit. A sudden cessation of smoking was always advised, because "smoking is a typical all-or-nothing habit for almost all daily smokers.

"Very few will be able to cut down their consumption for any considerable time period. A complete and sudden stop is always advised. A relatively short-term but intensive effort, followed by long-term encouragement, is demanded."

Anger, not tension, behind desire to drink

By JEAN McCANN

OSLO, NORWAY — Helping alcoholics control their anger may also keep them sober, says a University of Washington researcher.

Dr G. Alan Marlatt said here he thinks it is not tension but inability to handle anger, that drives people to drink.

Drinking alcohol does not reduce tension or stress, he said. Moderate consumption will produce increased rather than decreased physiological arousal, and feelings of increased power and control.

"We used to think that after people left the hospital they just started drinking again because they craved a drink," Dr Marlatt told **The Journal** during an international conference here on Dimensions of Stress and Anxiety.

"When we looked at it, we found there were certain situations which were more likely to lead them to drinking than others — such as getting angry and being frustrated. If they don't know how to handle that anger they are more likely to begin drinking again.

"So the treatment for that is to specifically teach them how to assert themselves. This way, when they leave the hospital they will be able to handle situations in which they get angry more effectively, and they won't need alcohol."

Such training can include role playing in which the alcoholic rehearses scenes of potential anger.

The individual also learns to "self-instruct" when a provocative situation arises, along the lines of "I'm feeling anger now, and what I should be doing is expressing myself assertively. I'll be constructively assertive without getting too angry."

Dr Marlatt said he feared too little of such training was being done because of the prevalence of the "disease" concept of alcoholism.

Drinkers should also be trained in social skills as an antidote to problem drinking, he said.

Such training, which is now going on at the Veterans' Administration hospital in Washington, involves use of a tape recorder depicting certain situations which could be tempting to the alcoholic: "For example, we'll ask him to imagine that he's at a wedding reception; and someone asks him to toast the bride. We ask him what he would do in that situation and after that, he can rehearse appropriate responses."

Reporting on a study of social drinkers at the University of Washington, Carole Kosturn said individuals drank more if they were insulted during the staged experiment without opportunity to retaliate.

This bears out Marlatt's hypothesis, she said, that "situations such as experiencing frustration and anger are related to relapse or increased drinking for the alcoholic.

"Treatment programs which emphasize role-playing and modeling, along with self-instructional procedures, may enable the alcoholic to 'innoculate' himself against potential relapse situations. Social skill training and self-control procedures may also prove effective in the prevention of problem drinking if applied to the high risk population of social drinkers — at high risk for future alcoholism," she said.

Cigarette smoke endangers infants

By BETTY LOU LEE

TORONTO—Living in an environment of cigarette smoke may enhance the risk of crib deaths in babies, a University of Washington team in Seattle has concluded after a statistical study.

Dr Abraham B. Bergman of the department of pediatrics and health services, told the Ambulatory Pediatric Association meeting here that passive smoking could not, alone or in combination, be said to cause sudden infant death syndrome (SIDS). But, it "joins the list of eligibility factors which appear to enhance the risk."

In a study of 56 families who had lost babies to SIDS and 86 control families, 59% of SIDS mothers smoked after the baby was born, compared to 37% of control mothers. The SIDS mothers also smoked a greater quantity of cigarettes.

The study was begun because of a chance remark by a physician who regularly attends meetings of SIDS parents. "You can hardly breathe at those meetings. . . .It's not ordinary smoking. One's asphyxiated by it," Dr Bergman told the association.

It is already known that smoking mothers are more likely to produce low birth weight infants, and that babies of smoking parents appear to have more frequent respiratory infections. A Queen's University, Kingston group also reported in 1968 that 68% of SIDS mothers in Ontario smoked during pregnancy, compared to 40% of control mothers.

Dr Bergman said the birth weights of the babies in the SIDS and control groups did not differ significantly.

"Does cigarette smoke act as an irritant to the respiratory mucosa, or depress the immunologic response to viral antigens, or both? The answer is not known. It seems logical, however, that similar mechanisms are at play in the association of both SIDS and lower respiratory infection to passive smoking."

The questionnaire used for the study also compared the ingestion of Aspirin, cold remedies, coffee, tea and cola drinks, and found no difference between the two groups.

A possible flaw in the statistical reliability of the study is the fact that 43 of the SIDS families, 56%, moved without a tracing address after their babies died. Dr Bergman said it was "conceivable, but not likely" their smoking habits differed significantly from the responders.

There was no significant difference in paternal smoking among the two groups. More SIDS mothers also smoked during pregnancy — 61% compared to 42% of control mothers.

There has been a wealth of speculation in the past about the cause of crib death, but none of the theories has been proven valid in terms of a single etiology. "Eligibility factors" statistically compiled include non-Caucasian race, low birth weight, lower social class, male sex and presence of a viral infection.

High hopes for 'hangover cure'

HELSINKI — Hangovers and possibly the acute withdrawal syndrome of chronic alcoholism might be curable if doctors would attack with drugs the central nervous system effects of intoxication and not the extra-CNS effects.

This is the opinion of Dr. Reino Ylikahri of the department of medical chemistry at the University of Helsinki, based on extensive studies of the etiology and pathogenesis of hangover.

He told a general session here of the International Institute on the Prevention and Treatment of Alcoholism that central and peripheral effects of catecholamines are probably the important factors in hangover and withdrawal.

The hormonal effects of alcohol, he said, may have some significance also since they are mediated through the CNS. At least, "adrenergic over-activity seems to be important."

As for "metabolic and physiological effects of ethanol outside the CNS", however, "they have a minor role in the pathogenesis of hangover, and probably of alcohol withdrawal symptoms in general."

Dr. Ylikarhi said he studied hangover because "although hangover has been known for thousands of years, it has received very little scientific interest...although it is common even among occasional drinkers, and causes a huge loss of working days."

Another reason is that hangover "is a kind of miniature model of the severe alcohol withdrawal symptoms of chronic alcoholics that are known to constitute a significant obstacle to the interruption of drinking."

Dr. Ylikahri said that while some claims have been made that hangover is due to lack of sleep, to smoking, to uninhibited behaviour during intoxication, or to contents of the drink other than the ethyl alcohol itself, it is more likely the alcohol itself that is largely responsible.

For example, it induces metabolic changes in the liver which affect the rest of the body, causing "unpleasant feelings". Also ethanol itself has direct pharmacological

By JEAN McCANN

effects. These principally affect the central nervous system and they cannot be blocked by the inhibition of ethanol oxidation. Intoxication is caused by these neuropharmacological effects of alcohol and since hangover is correlated to the previous degree of intoxication, these direct effects may also play an important role in the pathogenesis of hangover.

"The pharmacological effects of alcohol also affect the endocrine apparatus of the body, which is closely connected to the central nervous system. This results in hormonal disturbances which may contribute to the symptoms of hangover."

His studies convinced him many commonly-held beliefs about the role of metabolic changes in the pathogenesis of hangover were not true.

For example, under laboratory conditions, and using pure, undiluted alcohol, he found that acetaldehyde levels could not be responsible for hangover because they were high during the acute intoxication phase but almost negligible during the hangover phase.

The intensity of hangover did not correlate either with concentrations of glucose, lactate, ketone bodies, or free fatty acids in the blood — other factors which some have claimed responsible for hangover symptoms.

Studies of the after-effects of alcohol on the plasma electrolyte concentrations and the capillary blood acid-base balance, also showed "no significant changes in the concentrations of sodium, potassium, chloride, calcium and magnesium in plasma during intoxication or hangover." There also was no correlation between the concentration of these ions and the intensity of hangover.

Minor tranquillizers

CMA wants tighter drug controls

CALGARY—The Canadian Medical Association will ask the federal government to place minor tranquillizers and sedative-hypnotics on the schedule of controlled drugs (Schedule G).

It acted on the recommendation of its sub-committee on the non-medical use of drugs, headed by Toronto psychiatrist Dr Lionel Solursh. He said the committee was particularly concerned with diazepam and chlordiazeponide (Valium and Librium).

In its report to the CMA general council, the committee said: "The medical profession continues to contribute to the misuse of minor tranquillizers, sedative-hypnotics and narcotics. Irresponsible prescribing, multi-physician prescribing, theft and forging of prescription pads, and illicit sale all lead to the misuse.

"The availability of some substances is contributing to major health hazards — e.g. diazepam has replaced acetylsalicylates as the commonest cause of poisoning in children."

If the government complies, prescriptions for these drugs could be renewed only three times, and then only in writing, not by telephone. The pharmacy records would also permit federal cross-checks by computer to identify patients or doctors who might be abusing prescriptions.

New Books

By RON HALL

Drugs Demystified

. . . by Helen Nowlis
The Unesco Press
(7 Place de Fontenoy
75700 Paris, France), 1975.

Dr. Nowlis describes the four major models of drug use, the effects of drugs, and the different types of use. A psycho-social model is proposed and strategies for prevention are discussed.

The Complete Handbook of Peer Counseling

. . . by Mimi and Don Samuels
Fiesta Publishing Corporation
(1515 N.W. 7th Street,
Miami, Florida 33125), 1975.
bibliography: 191p.: $5.95

The authors have taken a practical approach in describing the organization, implementation, and evaluation of a peer counseling program. Details on the selection of trainees, training schedules, arousing interest, and confidentiality are presented. A 15-day training cycle with specific objectives is described, and questionnaires accompany the discussion of the program evaluation.

The Drug Epidemic

. . . by Ari Kiev
The Free Press,
(866 Third Avenue,
New York, New York 10022), 1975
243p.: $8.95

Composite experiences of addicts are used to trace the stages in the development of drug abuse from experimentation to total absorption in the drug subculture. Drugs and drug groups are defined; the jargon, effects, and dangers are briefly outlined; and addicts' experiences are used to answer specific questions. Development of criminal behaviour, therapeutic programs, treatment, prevention and community organization are also detailed.

Other book received

Beyond Drugs: Einstein, Stanley Pergamon Press, Inc., Toronto, 1975, 290 p.

Let the Children Speak. Light, Patricia K.D.C. Heath and Company, Toronto, 1975, 95 p., $11.

Investigation of Narcotics: Superson, Edward T. Citadel Press, Inc., Sacramento, 1975, 159 p., $8.50

Journey Back: Escaping the Drug Trap: Kastl, Albert J., and Kastl, Lena. Nelson-Hall Company, Chicago, 1975, 216 p., $6.95

The Speed Culture: Amphetamine Use and Abuse in America: Grinspoon, Lester, and Hedblom, Peter (eds.) Harvard University Press, Cambridge, 1975, 340 p., $15.

Drugs and Athletic Performance: Williams, Melvin H. Charles C. Thomas, Publisher, Springfield, 1974, 199 p., $10.75.

A Primer of Drug Action: Julien, Robert M. W. H. Freeman and Company, San Francisco, 1975, 290 p., $4.95.

Crime, Rape and Gin: Crick, Bernard. Prometheus Books, Buffalo, 1974, 96 p., $7.95.

The Hidden Alcoholic in General Practice: Wilkins, Rodney H. Paul Elek (Scientific Books) Ltd., London, 1974, 241 p., $20.75.

Governmental Response to Drug Abuse: Cline, Sibyl, and Akins, Carl. Drug Abuse Council, Inc., Washington, 1975, 36 p.

"High" States: A Beginning Study: Zinberg, Norman E. Drug Abuse Council, Inc., Washington, 1974, 51 p.

Pot Luck in Texas: Changing a Marijuana Law: Danaceau, Paul. Drug Abuse Council, Inc., Washington, 1974, 70 p.

Street Status and the Drug Researcher: Issues in Participant-Observation: Feldman, Harvey W. Drug Abuse Council, Inc., Washington, 1974, 63 p.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

Seventh Annual Summer School on Alcohol and Other Drugs — August 4-15, Berkeley, Calif. Information: Herman J. Kregel, Director, Berkeley Center for Alcohol Studies. Pacific School of Religion, 1798 Scenic Ave., Berkely, Calif. 94709.

The Nurse Faces Alcoholism — A Practical Approach — Aug. 5-Aug. 9, Amityville, N.Y. Information: South Oaks Foundation, Alcoholism Education Center, P.O. Box 426, Amityville, N.Y. 11701.

Seminar on Alcoholism — Aug. 6-15, Chicago, Ill. Information: Ms. Mary Ellen Shallis, 122 S. DesPlaines Street, Chicago, Ill. 60606.

National Consultation on Problems of Alcohol and Drug Dependence of Women — Aug. 15-16, Quebec City. Information: Mr. D. Taylor, Executive Vice-President, CFADD, 451 Daly Ave., Ottawa, Ont. K1N 6H6.

Institute on Addiction Studies — August 17-22, McMaster University, Hamilton, Ont. Sponsored by Alcohol and Drug Concerns, Inc. Information: David Reeve, 15 Gervais Drive, Don Mills, Ont.

New England School of Drug Problems — Aug. 17-22, University of Vermont, Burlington, VT. Information: Jan S. Durand, Coordinator, P.O. Box 11009. Newington: CT 06111.

The National Alcoholism Training Program for Professionals will hold eight seminars from September 1975 to May 1976, St. Louis, Missouri. Information: Dr. D. J. Pittman, Social Science Institute, Box 1202, Washington University, St. Louis, Missouri 63130.

Fifth International Conference of the International Association for Accident and Traffic Medicine and the Third International Conference on Drug Abuse of the International Council on Alcohol and Addictions — Sept. 1-5, London, England. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Fifth United Nations Congress on the Prevention of Crime and the Treatment of Offenders — Sept. 1-12, Toronto, Ont. Information: P.O. Box 1975, Station "B", Ottawa, Ont. K1P 5R5.

1975 Annual Meeting of the Alcohol and Drug Problems Association of North America — Sept. 14-19, Palmer House, Chicago. Information: Alcohol and Drug Problems Association of North America, 1130 Seventeenth St., N.W., Washington, D.C. 20036.

Canadian Foundation on Alcohol and Drug Dependencies — Sept. 14-19, Quebec City. Information: OPTAT, 969 Route de l'Eglise, Quebec 10e, P.Q. G1V 3V4.

Ontario Consultation on Women, Alcohol and Drugs — Sept. 29-Oct. 1, Ottawa, Ont. Information: Ms. L. Pinder, ARF Regional Office, Suite 202, Pebb Bldg., 2197 Riverside Dr., Ottawa, Ont. K1H 7X3.

Interdisciplinary Conference on Conjoint Emergency Care — hosted by the Emergency Nurses Association of Ontario — Oct. 1-3, Toronto, Ont. Information: Ms. M. Victoria Eld, Apt. 5, 62 Old Mill Road, Etobicoke, Ont. M8X 1G7.

Symposium on Headache — Oct. 4, Toronto, Ont. Information: The Director, Office of Postgraduate Medical Education, University of Toronto, Toronto, Ont. M5S 1A8.

49th Annual Convention of the American School Health Association — Oct. 8-12, Denver, Colorado. Information: American School Health Association, ASHA National Office, Kent, Ohio 44240.

International Symposium on Alcoholism — Oct. 11-13, Porec, Yugoslavia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Conference on Alcoholism and Drug Dependence — Oct. 26 - Nov. 1, Sao Paulo, Brazil. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Third Annual Conference of the California Association of Alcoholic Recovery Homes — Oct. 31 - Nov. 2, Asilomar, Calif. Information: Joe Collins, Executive Director, CAARH, P.O. Box 5396, Santa Monica, Ca. 90405.

Fourth Information and Feedback Conference — Nov. 12-13, Toronto, Ont. Information: IF Conference Committee, Counselling and Development Centre, York University, Toronto, Ont.

First National Conference on Occupational Alcoholism and Drug Abuse — Nov. 17-20, Ottawa, Ont. Jointly sponsored by Humber College and Addiction Research Foundation. Information: Jim Simon, ARF, West Toronto Branch, 4143 Dundas St. W., Toronto, Ont. M8X 1X2.

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Send resume and salary expected to: Personnel Committee, 23 Charles East, Kitchener, Ontario no later than September 3, 1975.

The Indian war on alcohol

A Special Report by Harvey McConnell

TRYING TO remove the black cloud of alcoholism that for more than two centuries has enveloped the North American Indian in squalor and despair is an awesome task.

Yet in less than a decade alcoholism programs directed and run by Indians in Canada and the United States have made tremendous strides.

The key is as old as the Indian tribes: It is a revival of the spiritual life which from unrecorded time until the arrival of the white man formed the basis of Indian daily existence. A spiritual life which alcohol and Christianity nearly obliterated.

Statistics about alcoholism among Native Americans, as Indians rightfully feel they should be called, are depressing in the extreme: Latest estimates put the incidence at 80% in men and 60% in women

John and Beatrice Bradford

Some 90%-95% of all families are affected by alcohol in one way or another.

More than 80% of college students and 50% of high school students drop out because of alcoholism.

Time and again one hears that at least 75% of all deaths among Indians can be traced to alcohol in one way or another.

The problems are the same for all North American Indians, who look on the Canadian-American border as an artificial boundary created by the white man.

Reactions to the revival of spirituality as a means to combat alcoholism and to give back to the Indians the dignity they have lost, can be dramatic and unexpected.

It was the response by one community to the death of a baby that last spring provided tangible proof to the leaders of Canada's newest Indian alcoholism program that there is hope in even the most seriously affected communities.

John and Beatrice Bradford, who set up the program for Grand Council Treaty Number Nine in Timmins, Ontario, and four other team members had returned discouraged after a month at Poplar Hill, 87 miles west of Redlake in Northwest Ontario.

They felt they had made no real impact on the community which is noted for its high rate of alcoholism and sporadic outbreaks of violence.

Previous visits to four other communities had been highly successful: People had come to accept that they had a drinking problem and had been helped to set up a local alcoholism council. They had begun to see spirituality as a key.

Poplar Hill would be the first complete failure in the year-old program which Mr Bradford directs. Ms Bradford supervises health and social services aspects.

"Then the word came down that when the baby died at Poplar Hill, the people sang and drummed for three nights.

"We were really excited. We felt 'There is a link, we can get to them'," says Ms Bradford.

While there may be public demonstrations of spirituality, as in the drumming and singing, in day-to-day life spirituality is a very personal thing for an Indian.

Ms Bradford explains: "Native spirituality is the belief that each Indian has in himself and the way that he sees the Great Spirit. It is a very personal inner-circle kind of thing, the sound basis for the centre of yourself. And it is really important to the Indian people.

"The Christian people have made the Indian people ashamed of their spirituality and it is going to take time to convince the Indian people that it is nothing to be ashamed of."

Although the Bradfords are encouraged by their success after one year, they realize it is going to be a long haul.

Geography works against them: 30 of the 41 Indian communities in Northern Ontario can only be reached by air. Their area of operation extends from the Manitoba border to the two most northern communities on Hudson's Bay, Fort Severn and Winisk.

In some of the communities the whole population, including children, is addicted to brews from dates, raisins and prunes or anything else fermentable or distillable.

Many young people also sniff gasoline and suicide is common.

Although there are a number of programs for Indians in Canada, most are concerned with those living in urban areas. The Grand Council Treaty Number Nine is the first in Ontario for Indians in the northern half of the province.

'Until we get our dignity back, it's going to be hard to sober up Indians'

Teams from Timmins never visit a community unannounced, says Mr Bradford.

"We cannot and will not go into a community or reserve without either a Grand Council resolution or an invitation from the chief.

"We stay out of politics as well. We are a delivery service and that is all we are interested in. This is one of the rules when we go into a community. If there are any politics involved our president, Andrew Rickard, will take care of that."

When they are invited into a community they stick to a fundamental part of Indian culture: "You must walk like you talk."

Because of the distances involved, and the fact that spring breakup and fall freezeup limit them, the teams always go in for a month. Everything from food to sleeping bags has to be packed in.

Living quarters are primitive in the extreme: They stay in abandoned houses. "And if nobody wants to live in it, you can imagine what it is like," Mr Bradford observes.

THE BACK PAGE

"Our whole purpose is to let the people accept and acknowledge that they have a problem. When they do, then we ask them what they are going to do about it and then we suggest the ways of getting started."

When a community decides to set up a program, it also chooses its own board of directors. It is up to the Bradfords to find the funds to sustain it.

In the past month the Grand Council Treaty Number Nine program has been expanded into two sections: One team makes the initial visit and a second team follows later to provide technical assistance and a continual support system to the community council.

"We hope it will give the local people the skills to carry on the program," Ms Bradford adds.

Proposals are now on the way to Ottawa for help in funding the local programs from the national Native Alcohol Abuse Program.

Alcoholism is not the only problem that besets many of the communities. Ms Bradford has found from her own experience, for example, "that while there are many good nurses working up there, too many of them are just there for the money. And some teachers are excellent, but we also know of others who try and use alcohol to seduce their young women students."

Venereal disease has also appeared in areas where mining operations have started, especially around Osnaburg, which is considered with Poplar Hill, to be the community with the worst alcoholism problems.

One of the leaders of the American drive against alcoholism has been Herb Powless who, after five years working with Indians in his native Wisconsin, is now easing himself out to assist Indians ensnared with the law.

He helped set up the National Indian Board and is also an active member of the politically-oriented American Indian Movement.

Herb Powless, one of the US leaders of the war

Mr Powless, a recovering alcoholic, says when the campaign to help Indians in the US started in earnest, there was less than a million dollars available for some 40 programs. Now there is a budget of $16 million for more than 200 programs.

"Indian people identify with their own people and only we can help ourselves in this field — through our self-identity, through our cultural awareness — to find out who we are and what we are. With these we have found a significant role in our sobriety and in sobering up.

"We have almost been destroyed through the mainstream. We have been Christianized, we have been decultured, we have been wards of the government, we have been told what to do for the past 200 years."

An example is the 1950 decision by the Bureau of Indian Affairs to bring Indians into the cities to train them and have them assimilate into that society.

"In fact," says Mr Powless, "it was a genocide program set up by the government, and all it actually resulted in was that the Indian people came into the major cities and ended up in the ghettos or skid row."

An especially tragic figure is the Indian woman alcoholic, who has been studied extensively by Canadian-born Ms Wanda Frogg, who now lives in the US with her husband. She is a member of the Indian Review Board of the National Institute of Alcohol Abuse and Alcoholism.

Ms Frogg points out that when the Indian was introduced to alcohol, there were no cultural norms for its use and his natural instinct was to share it with his fellow Indians.

So far bans have never worked and attempts to prohibit Indians from getting alcohol have been just an added attraction.

Herself a recovering alcoholic, Ms Frogg said: "I have yet to meet a Native American who is a social drinker. I have met many who consider themselves to be."

Most Indian women grow up in families where parents and relatives are alcoholics. More often than not they marry alcoholics, who eventually abandon them. If they live in cities they often have to take to the streets.

Children of an alcoholic mother frequently do not attend school regularly or drop out simply because they have inadequate clothing or food. At other times, as Ms Frogg found while working one summer on a reservation, eight- and nine-year-old children have to be sent home because they are drunk.

"One of the greatest difficulties in persuading the Native American woman to admit to her problem and seek treatment is that she is sorely afraid her children will be removed from her if she admits to alcohol abuse, says Ms Frogg.

"Even when she is willing to admit she has a problem, she is afraid of any prolonged absence from home for treatment because this may cause the loss of her children."

She adds: "New housing, economic development and education, or any other social programs, are not the answer if we cannot sober up and cannot take advantage of them."

When they began their program, the Bradfords were often asked what the Indians had lost to produce such a high rate of alcoholism.

"I think it is the loss of dignity, because every human being has to have his dignity and we have lost that. Until we get it back it is going to be very hard to sober up Indians."

Not that the return to spirituality does not cause conflict among Indians. It does.

Christian religions, says Ms Bradford, have divided them into sects even within single communities and some will find it hard to reject the Christian beliefs after years of having them drummed into them.

But, as Mr Bradford points out: "I don't care what kind of spiritual life you have or what it is you are looking forward to, but that is the most integral part of our lives.

"That is what kept us together, that is what helps us in our work because Native American people daily are very, very religious, if you want to use the term, and everything relates to spirituality. Hopefully we can get back into this.

"We can't go back to the native way of life of years and years ago because we have to adapt. But I think spirituality is the most important aspect of it. We all need help, and that is the only place we are going to get it."

Next month The Journal looks at new statistics on native drinking in Kenora, Ontario

Great scarlet poppy poses new threat

URGED ON by the American Medical Association and pharmaceutical manufacturers, the government may soon decide to permit commercial cultivation of a poppy plant that could be processed into abusable drugs far more potent than heroin.

Substances several hundred times heroin's potency could be made — cheaply and easily — by college-trained underground chemists.

The poppy plant is the Iranian great scarlet poppy (*Papaver bracteatum*). It produces a large, red blossom, and even now is widely sold in the US for ornamental use in gardens.

A few plants, or a few dozen, pose no risk. The yield per plant is small.

But Mallinckrodt, Inc., of St. Louis, a major chemical company and one of the three US processors of raw opium, envision a three-to-five-square mile carpet of great scarlets somewhere in the west.

The great advantage of the great

By DAVID ZIMMERMAN

scarlet is that it yields a substance, thebaine, that can be used to make several narcotic drugs, particularly codeine.

Unlike the opium poppy (*P. somniferum*), the current natural

— See Backgrounder page 9 —

source for codeine, the great scarlet yields little or no opium, the raw material for morphine and heroin.

Hence, it is widely touted by AMA, pharmaceutical, and government officials, as a safe alternate source of codeine — which now is in short supply.

"The AMA urges . . . that the great scarlet poppy be cultivated in the US in sufficient quantity to make the US independent of outside sources," AMA president, Dr Malcolm Todd, wrote to President Gerald Ford last year.

"This poppy," he continued, "yields material that can be converted to codeine, a drug of low addiction potential, and cannot by any process known be converted to morphine or heroin. An adequate domestic crop of great scarlets could be an important factor in the control of opium production and its diversion to illicit uses."

Dr Todd made no reference in his letter to the great scarlet's potential for abuse. The AMA since has reaffirmed its support for cultivation — despite warnings that emerged.

Thebaine, the great scarlet's principal extract, is not itself a substance of abuse.

See — Great — page 3

The Journal

VOL. 4 NO. 9 PUBLISHED MONTHLY BY ADDICTION RESEARCH FOUNDATION TORONTO SEPTEMBER 1, 1975

Support through an alcoholic haze

Sights like the one above are commonplace in Kenora, Ontario, where, according to a new report, nearly three-quarters of violent Indian deaths are alcohol-related. Full report on page 4.

Alcoholism prevention efforts

Schools, media are scapegoats

By ANNE MacLENNAN

SEATTLE, WASH. — The public is naive and irresponsible in trying to foist onto schools and media advertising campaigns the task of discouraging heavy alcohol use, an American authority claims.

There is no question the need is urgent to place a high priority on programs to discourage development of heavy drinking, particularly among young people, Dr Don Cahalan told a conference here on Behavioral Approaches to Alcoholism and Drug Dependencies.

It is among those under 25 years old that the incidence of drinking problems is highest and the evidence suggests heavy drinking is increasing in this group, he said.

But, "passing the prevention buck" to the schools and pushing for more media advertising campaigns will not work, he said.

Dr Cahalan, professor of behavioral sciences in residence and director of the social research group at the School of Public Health, University of California, Berkeley, was reporting on 15 years of research into American drinking practices and problems.

With others, he has conducted 12 attitude surveys in Bay Area North California and five national surveys. He is also author or co-author of three major books based on the results of these studies.

He criticized the public for its evasive attitude to taking any responsibility for prevention of drinking problems.

"It is willing to pay lip service to prevention of alcohol problems but unwilling to do anything about it except pass the problem to schools and media."

Schools, he said, are the "dumping ground" for things people are unwilling to teach their own children in their own homes or neighborhoods by example. Television and radio advertising campaigns are "another popular form of educational substitute-activity".

"The media-advertising approach is effective in switching consumer purchasing from one branded product to another nearly-identical product; but this is

See — Schools — page 4

Don Cahalan

1984 — It's more than nine years away

SEATTLE, WASH. — Claims that behavioral conditioning techniques can now or will ever be used to change dramatically the way a person or a group of people behaves simply add arrogance to ignorance, says a Rutgers University authority.

"The evidence demonstrates it is extremely difficult to create classically conditioned reactions in humans," Dr. G. Terence Wilson told a conference here on Behavioral Approaches to Alcoholism and Drug Dependencies.

Dr Wilson is associate professor, graduate school of applied and professional psychology.

"Moreover, the evidence is quite unequivocal that patients have available to them a variety of counter-control manoeuvres which very effectively preclude any (unwanted) influence of a therapist of 'controller'," he said.

Even in ementine conditioning for alcoholics "which is certainly

See — Conditioning — page 2

Master Radish and Miss Corn

Defensive weapons against drug abuse

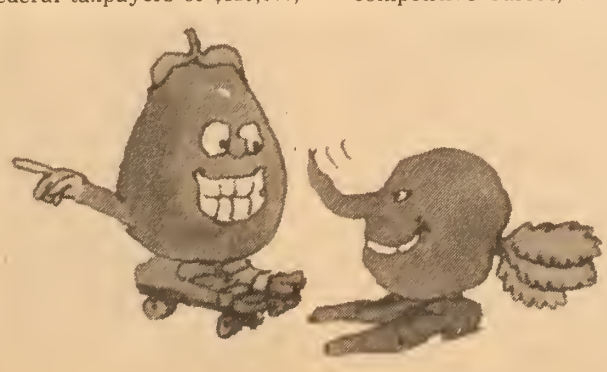
By BRYNE CARRUTHERS

OTTAWA — After three years of quiet preparation, the federal government's Non-Medical Use of Drugs Directorate is ready to spring "Project Vegetable Farm" on the classrooms of the nation.

But "Project Vegetable Farm" is a markedly differently foray against the evils of drug use: It is a "defensive" weapon intended to prevent drug abuse by reinforcing positive values.

"Project Vegetable Farm" features an educational story book entitled "The Hole in the Fence" (En Francais, "Mes Amies, Mon Jardin) that stars a cast of 20, all of them (with the exception of the fungus Mushroom) vegetables.

The vegetable characters, created and placed in their story book niches at a cost to federal taxpayers of $120,000, include the outspoken Master Radish and Miss Corn, the naive tot Brussel Sprout, the overcompetitive Carrot, the bully Cucumber, the grumpy old adult Mr. Cauliflower, the wise and helpful parent Mr. Cabbage, the clumsy youngster Potato, the fat and thin pair Pumkin and Asparagus, and the "mysterious" Mr. Mushroom.



Eggplant and Master Radish

And in case you hadn't already guessed, Mr. Mushroom is the most important visitor to the garden world, entering from outside through the Hole in the Fence, bringing with him tales of greener pastures, and offering a "Magic Potion" solution to everything — at a slight price, of course.

The well-illustrated story book, which Non-MUD hopes to sell to interested schools for

See — Vegetarian — page 2

Anyone for coffee?

...INSIDE

Lowered drinking age boosts alcohol use

OTTAWA — The lowering of the drinking age in Canada to 18 years has undoubtedly been a major factor in the continued increase in drinking in the country, especially among young people, according to the head of the federal government's health protection branch.

Dr A. B. Morrison, a non-drinker himself, told **The Journal** the move by provinces was a way of "legitimizing" alcohol consumption for a very large sub-group of the population — a sub-group which he and others suspect is more susceptible to the high-pressures of liquor industry advertizing.

At the same time, he noted two things: No one knows "definitively why people are drinking more"; and the escalation in alcohol consumption is a world phenomenon, not a problem limited to just Canada and the United States.

Around the world, the economic, political and, most recently, the energy troubles, might together be a factor pushing individuals to drink more, Dr Morrison suggested.

In Canada, the self-serve liquor store could very well be another factor, especially when combined with younger legal drinkers.

"When you make it legal for an 18-year-old to shop around a self-serve store and select as much liquor as he or she wants, there's no question that you are encouraging increased consumption," Dr Morrison said.

"In fact, we may very well be laying the foundations for an increased alcoholism problem among young Canadians in the future."

By BRYNE CARRUTHERS

Dr Morrison did not think the sale of the larger 40-ounce bottle is itself a significant factor. Some experts have suggested that the availability of the larger bottles encourages people to drink up their home stocks of liquor that much faster. Counteracting this would be the recent higher costs for most alcohol products.

But one area where cost may in fact be encouraging use of alcohol over non-alcoholic beverages is in the soft drink-beer thirst-quenching summer drinking pattern. The price of sugar increased so dramatically recently that in some areas of Canada and the United States it is sometimes actually cheaper to drink beer than soft drinks.

Dr Morison also suggested that affluence, and the affectations of affluence (such as emphasis on consumption of wine and spirits instead of beer), have probably combined with the previously-mentioned economic anxieties to spur more alcohol drinking in Canada.

Meanwhile, drug abuse experts within the health protection branch have no indication that young people are replacing cannabis and other chemical drugs with alcohol.

Rather all the evidence gathered by the Bureau of Dangerous Drugs indicates that young people (and, as time goes on, older Canadians) are just consuming more alcohol along with other drugs.

The fact that alcohol and cannabis taken together, can cause more driving problems has given federal authorities more to be concerned about.

Dr. Morrison said he is worried about the correlation between increased drinking and an even greater increase in problem drinkers and the problems of drinking.

The latest alcohol consumption statistics show that in the fiscal year ending March 31, 1974, Canadians consumed almost 475 million gallons of alcohol (spirits, wine and beer), 6% more than the previous year and almost 30% more than the 1970 level.

Since Centennial Year in 1967, alcohol consumption has increased by 50% in Canada.

A vegetarian path to drug education

(continued from page 1)

under $2 a copy (including a teacher's guide for every 20 to 30 books) for use starting this fall and winter, contains 19 short stories — modern fables, so to speak, that focus on such things as cheating, lying, stealing, revenge, self-identity, discrimination, and "magical solutions".

Ron Draper, head of Non-MUD, says it's a whole new approach to drug education, based on the not-so-new education concept of "value reinforcement" (or "valuing" as the educators and psychologists have nicknamed it).

Using stories and the vegetable characters as vehicles, the idea is to let young children see for themselves the long-term pitfalls of cheating and stealing and lying; the real problems of justice and friendships in this harsh world of children and adults; and the fact that all people have weaknesses and strengths. Of course, there are not-so-veiled lessons about drugs: how properly to use medicines and how "magic potions" are not "real" and are not solutions to problems.

Mr. Draper, who has placed much of his reputation on the line with this project, says the story book full of fables has several advantages over the traditional drug "fact sheets" and "scare campaigns".

It is not substance oriented, though admittedly it gets children thinking about drugs, even in Grades 2 and 3. Therefore there is less danger of sparking a curiosity about and then use of specific drugs, he suggests. The hope is that once the general "value" that "magic potions" are no solution has become ingrained, the children might later seek out information on specific drugs by themselves.

"It deals with drugs in the context of other choices children learn they must make," Mr Draper said.

The federal government has recently started approaching provincial education departments, offering the material for use in schools. Non-MUD officials estimate they will need a minimum order of 25,000 booklets to enable a second-run printing.

Mr Onion — all forlone

Provincial education experts have in one way or another been involved or aware of the project since its inception three years ago, Non-MUD says.

The idea was tested at a conference of federal and provincial drug experts in the fall of 1971. After a very positive reception to the idea, a panel of education consultants helped prepare the story book contents.

And most recently, the material has been tested on students and teachers, in Ontario, Quebec and Nova Scotia.

The 6,000 first-printing books are now available for any schools wanting to start this fall term. But the pre-testing will result in some changes in the second printing.

One group of Nova Scotia teachers put their fingers on some potential problems during a pre-test. Some said they would not dare use it until they obtained permission from parents, arguing that it introduced the concept of drug use at too early an age.

(The children in the pre-test classes indicated that even at ages six to nine, they could quickly put two and two together and come up with drug use, including drinking alcohol, when the Mushroom's "Magic Potion" was mentioned in a story. So the children may not be as naive as many believe, even at that tender age.)

Other teachers noted that to be given a chance of success, the project had to be followed in subsequent grades, right through high school if necessary. Otherwise, the value of "valuing" would be quickly lost.

Mr Draper says that if the approach is successful, it will be a "cornerstone" to a more extensive educational program that might ultimately include material for use in the home.

The question still unanswered is whether the federal government or the provincial governments will have to take up the baton once this experiment shows its worth.

The French and English versions were created separately. They share the artwork and the general thrusts of the story lines. But beyond that (as the titles indicate — The Hole in the Fence and, translated, My Friends, My Garden), they are quite different.

The Non-MUD officials and some educators also worried about using vegetables for characters, since kids tend to dislike vegetables so intensely. But the pre-tests seemed to suggest the children treated the vegetables as characters separate from their organic reputations as foods.

The storybook only uses 19 of the 41 story lines prepared by the consultants.

This fact, according to Mr Draper, gives Non-MUD a headstart on Volume II — if during the next few months the provinces and the schools within their jurisdiction decide to make the first volume of "The Hole in the Fence" a best seller.

NMUD project stresses positive values

OTTAWA — The new drug abuse educational project, code named "Vegetable Farm," was conceived when "it became pretty evident that traditional methods weren't all that effective".

Ron Draper, head of the federal Non-Medical Use of Drugs Directorate, said: "Fundamentally I believe education efforts are still basic" to preventing drug abuse.

"But when I was told that the substance-oriented approach was doing more harm than good, by arousing curiosity, I then became interested in an approach that wouldn't promote drug use."

The result is the story book "The Hole in the Fence," with its cast of 20 vegetable characters. It attempts to inculcate positive values, including the fact that drugs as panaceas are not needed and do not exist anyway. The approach is called "value activation or reinforcement" by educators.

Mr Draper also likes the story book approach, with its fable-like stories, because it does not preach. It supposedly lets the children (in this case ages six to nine) make up their own minds (with a lot of help from the story tellers and stereotypes used).

During one pre-test, Mr Draper says he was "amazed at how quickly, even under less than ideal conditions, a class focussed on the value issues in discussions following the story."

Mr Draper says that as far as he is concerned, the "Vegetable Farm" project is perhaps *"the biggy,* since I'm so thoroughly sold on its fundamental validity." He adds that "if it is as good as I believe it is, it should provide a cornerstone on which we can build upwards through the school system and ultimately into the family environment."

He admits, though, that "it's an article of faith that the values inculcated by such education projects will stick."

As for the federal role in education, which is within provincial jurisidction, Mr Draper says the strategy of Non-MUD "is to develop a product and then make it available at as modest a cost as possible" to schools.

Ronald Draper

Conditioning doesn't spell brainwashing

(continued from page 1)

an extremely aversive venture, even if the conditioning 'takes' or works, subjects can easily go down to a bar, gag down a few drinks and they're off and running again.

"It is not as though something has been imposed on people over which they have no control."

As for suggestions that conditioning is some form of mass brainwashing, they simply miss the point, said Dr Wilson.

Behavioral therapy is a multi-faceted approach. The therapist, acting as problem solver, tries to detail treatment to the individual's particular problems. It's a very personalized approach".

"This is diametrically opposed to the frequent stereotype and unfortunately sometimes practised version of behavior therapy where clients with different problems are moulded to fit different techniques."

In the past, said Dr Wilson, behavioral treatment of alcoholics was too often synonymous with use of aversion conditioning techniques. And the use of behavior modification in general and aversive conditioning have generated a great deal of professional and public controversy resulting in a number of heated exchanges.

It has been called old-fashioned torture and brainwashing but of a kind that helps people, he said.

"It is quite clear that aversive therapy is a rubric that serves many different techniques and procedures. This set of procedures dominated the treatment of alcoholism until very recently with the advent of broad spectrum, multi-faceted behavioral treatment programs.

"Suffice to say, today the sophisticated concept of behavioral therapy is that it is a multi-faceted approach to particular problems of particular people.

"It requires a detailed behavioral assessment which is, without doubt, the most important aspect of therapy."

With respect to aversive conditioning the therapist needs the cooperation of the patient.

"At the very least he has to have confidence, trust and respect for the therapist. It has to be a mutually negotiated goal."

Informed consent is "absolutely crucial" and must be voluntary. The patient should know what he is entering into, should be competent to make decisions, and know, to the best of the therapist's ability, what the effects are going to be.

"I emphasize issues of both efficacy and ethics dictate this is a minimum necessity."

I'm Joan B and I'm an alcoholic...

It's the world's biggest-ever meeting of Alcoholics Anonymous and this is one of the few photographs ever to be released by that organization. Nearly 20,000 people from 29 nations attended the July meeting in Denver, many thousands participating via closed circuit TV to rooms near this main hall.

Great scarlet poses new threat

(Continued from page 1)

One expert says it has no narcotic effect on man.

A Mallinckrodt official says it actually is poisonous.

What advocates have not said, or tend to dismiss, is a warning that thebaine — whether derived from unsanctioned great scarlet poppy fields or diverted from licit channels — can be easily converted into abusable substances.

This warning has been most sharply sounded by Dr Sidney Archer, a professor of chemistry at Rensselear Polytechnic Institute in Troy, NY.

A specialist in the chemistry of analgesic drugs, he is "neutral" on the question of whether great scarlet poppies should be cultivated industrially.

But, he says, their "potential" for abuse needs to be taken carefully into account.

If great scarlet poppy cultivation were to put thebaine into the hands of illicit chemists, he says, the result could be a quantum change in drug trafficking, to the traffickers' advantage.

"It can change the logistics of transporting illegal drugs from [a matter of] kilograms to [one of] grams."

The Mallinckrodt company has been working on plans to cultivate great scarlets for thebaine for almost a decade. Ironically, their effort has received fresh impetus, and government research support, as the result of the now-rescinded ban on opium poppy cultivation in Turkey.

Opium poppies yield some, but not very much, thebaine which may be one reason why abusable substances derived from thebaine have not been much of a problem. There has not been much of it around.

Much of the crude opium from Turkish poppies has been diverted illicitly into the heroin trade. Crude opium that enters the US through licit channels goes to one of three companies federally licensed to process it. They are Mallinckrodt, Merck and Co., Inc., of Rahway N.J., and S. B. Penick & Co. of New York City.

The companies are known in the legal opium trade as "processors". They claim a perfect security record.

The processor sells the opium products to other companies, called "formulators," for final manufacture in prescription and over-the-counter drugs.

A tiny fraction is sold as dilute opium or paregoric, to control diarrhea. Somewhat more is formulated as morphine.

But by far the greatest percentage of the processors' sales — some 95% according to industry figures — is sold as codeine.

Thus, until now, opium has been virtually the only source of codeine. The Mallinckrodt plan calls for a major switch, from opium to thebaine, and from opium poppies to great scarlets, as one of the principal sources of medicinal codeine.

Besides its purported safety, several reasons are given for pursuing the great-scarlet-to-thebaine route to codeine, now that Turkey is back in the opium business.

As with oil, there is a wish for internal self-sufficiency. The thebaine route may be cheaper.

There is continuing concern that opium available from Turkey, India, Iran and other poppy-growing countries may fail to meet legitimate US and world codeine needs.

Perhaps most important, the demand here for codeine is rapidly rising.

The question of whether, and if so to what extent, other drugs could substitute for codeine has not been carefully explored, either by organized medicine or the federal government.

Also unexplored is whether there is a doubling every seven years in the mild-to-moderate pain Americans suffer which would justify the doubling of demand for the drug that is projected by the opium processors. (**The Journal**, April, 1975.)

In Britain, codeine use remains constant, while in Russia, according to US officials, codeine use has declined 25% in the last five years.

But in the current crisis atmosphere here occasioned by the very real, although perhaps quite temporary, codeine shortage, the development of an alternative codeine source has become more and more appealing to planners.

The codeine yield from great scarlets may be much greater than with opium poppies.

The Mallinckrodt procurement officer in charge of his company's great scarlet poppy project, Ray Stratmeyer, projects "six to 10 times the yield per acre" with the scarlets.

Mallinckrodt's projection, he says, is that it could fill 25% of codeine need with three — and certainly no more than five — square miles of densely planted great scarlets.

The company and the department of agriculture have for several years raised small, test plantings of great scarlets — in Beltsville, Md., Flagstaff, Ariz., Pullman, Wash., and sites in Idaho, Mississippi, Colorado, and Nebraska — and they find that, unlike the quite choosy opium poppy, it will grow virtually anywhere.

All of the steps in the commercial cultivation of great scarlets and the extraction of thebaine have not been worked out, but Mr Stratmeyer says it "looks relatively straightforward." Mallinckrodt, he says, is willing and eager to make the not-inconsiderable investment needed to begin.

The decision must come from the federal government. Mallinckrodt, or anyone else, can grow all of the great scarlets they wish — the plants are not controlled. But thebaine is a controlled substance, and there are strict — and relatively low — quotas on how much each company can produce in a year.

The man from whom the decision will come — he says — is Mr Edward Johnston, of the President's Office of Management and Budget. Mr Johnston is chief of the government's Opium Policy Task Force.

Dr Sidney Archer outlines formula he warns has potential for abuse — far greater than heroin's.

Nfld. creates alcohol, drug directorate

ST. JOHN'S, NFLD — Prevention, treatment and rehabilitation will be emphasized by the newly-created Alcohol and Drug Directorate in this province.

Announcing the formation of the new Directorate, Tom Doyle, minister of Rehabilitation and Recreation, pointed out that until now the Newfoundland government has had little or no direct involvement in the alcohol and drug dependence field.

Mr Doyle said the Alcohol and Drug Directorate (ADD) will report through him to the Social Policy Committee of the Cabinet.

The Minister said that for some time his officials, together with senior civil servants from various government departments and representatives of concerned private agencies, have been working towards establishing ways of focussing attention on "this most critical problem" and of forming the proper mechanism capable of responding to the needs of Newfoundlanders "in this important social problem area".

The directorate will be contacting various agencies and individuals throughout Newfoundland and Labrador to include as many viewpoints as possible in the planning and development of services.

Community agencies will be involved on a continuing basis as the work of the directorate proceeds, Mr Doyle promised.

"The Newfoundland government is most concerned over the growth of alcohol and drug abuse in this province and has great hopes the directorate will be successful not only in co-ordinating the resources of all appropriate government departments and private agencies to combat and prevent this problem, but also serve as a unique model for other parts of Canada," Mr Doyle said.

Chairman of the seven-member directorate is Dr Carl M. Stroh, consultant-psychologist, mental health division, department of health.

First nationwide meeting

Action for women launched

By ANNE MacLENNAN

LÉVIS, QUE. — Delegates to the first meeting in this country ever to focus on alcohol and drug abuse among women have passed a battery of recommendations to the organizers of the meeting, the Canadian Foundation on Alcohol and Drug Dependencies (CFADD).

The intensive, week-end consultation, held here near Quebec City, was aimed at stimulating action on behalf of women alcohol and drug abusers.

"As far as I'm concerned, we really got going what we wanted to," said Winnie Fraser, a member of the consultation program group and supervisor of the Addiction Research Foundation of Ontario — affiliated detoxification unit at 410 Dundas Street, Toronto. The unit caters to both men and women.

"We got reaction. There was frustration but that is not a bad thing. A lot of people came with great expectations, wanting immediate answers and immediate action.

"But, we were there to work and come up with reactions. They will lead to action."

About 45 women and men from across the country attended, representing workers in the field, women's groups, medical associations, government commissions, private agencies and services, and research institutes.

Working in small discussion groups, they formulated some 50 recommendations, many of them vague and not all solely concentrating on women. At the end of the weekend, they passed them to the program group of the meeting.

That group is expected to trim them into a more concise form and pass them to the CFADD program committee which in turn, is expected to pass a selected number of them to the CFADD board of directors at the annual meeting in Quebec City in September.

Recommendations are also expected to be part of a full report on the consultation to be presented at the annual meeting.

Working groups and recommendations, focused on women without resources, women at home and at work; youth; education/awareness; treatment; policy; the media; medicine; law and the criminal justice system; policy and legislation; and community development and mobilization.

Strangely, one point of conflict which surfaced was the very focus of the consultation — the emphasis on women.

Some delegates felt that if the meeting focused solely on women, they were "making the same mistake" as has been made traditionally when work focused on male abusers. They seemed wary of being seen as advocates of women's liberation.

Many others, however, and possibly the majority, felt that as the consultation had been organized explicitly to consider the problems of women discussion should naturally centre on women while recognizing that much of what was said might apply equally to men.

Among recommendations singled out by the program group for discussion at the final session were that:

- the Association of Medical Women be used as a voice to lobby the medical profession;
- that colleges of physicians and surgeons and other professional bodies be made more aware of non-medical helping agencies;
- that medical schools and other professional schools incorporate into curricula information relating to alcohol and drug use among women.

*** More on CFADD meeting in next issue of The Journal.**

Kenora Indians

Majority of violent deaths are alcohol-related: report

By MANFRED JAGER

WINNIPEG — The Indian Grand Treaty Council No. 3 says alcohol was a factor in nearly 70% of 189 violent Indian deaths in the Kenora, Ont. area between 1970 and June, 1973.

In a report published by the council but compiled and researched by a "concerned citizens' committee" and University of Manitoba investigators, the Indian group says alcoholism, sudden deaths, traumatic injuries and crimes among native peoples are prevalent and increasing.

The problems require major commitments of financial and human resources on the part of federal and provincial governments, and improved co-ordination of Kenora-area social services, the report says.

It recommends the establishment of a number of preventive programs and crisis services and suggests ways of helping Indians function in and deal with the legal system.

Researchers studied available information on sudden deaths related to alcohol use among the Indian people to form the basis for their report and recommendations.

They examined the circumstances of the deaths, the circumstances which led to the deaths, and the part played by alcohol. They admit to a combination of information gathering and "impressionistic stock-taking of the present situation" to draw together the report's material.

Of the 189 cases studied, the researchers determined these trends:

Most sudden deaths were accidental, the majority by drowning. More than two-thirds of the dead were younger than 40. Alcohol was a known factor in roughly 70% of the deaths. Men were more likely to die suddenly than women.

Victims included both drinkers and those who died as a result of actions by those under the influence of alcohol. Twenty-two of the victims were under 10 years old.

Of the deaths studied, 142 were labelled accidental, followed by 24 confirmed suicides and 12 suspected suicides. Homicide accounted for seven deaths, neglect for three. Drowning, gunshot, stabbing, fire and exposure were major death causes.

The researchers found the patterns in the sudden deaths held true for a study of the 1972 emergency records of the Lake of the Woods District Hospital.

A study of convictions for drunkenness in the judicial districts of Ontario for 1966 also showed that the districts of Kenora and Patricia have "far and away the highest rate of convictions per 1,000 population in Ontario — more than two times greater than the next highest district."

The Kenora district rate was 71 per 1,000 convictions. The next-highest figure was 37 per 1,000 in the Thunder Bay district.

The report lists several theories regarding the severity of the findings.

"One theory holds that Indian people are experiencing a great deal of difficulty in adjusting to the larger society . . . It is theorized that this problem of adjustment is at the root of many of the problems facing Indian people — family disorganization, lack of attainment in education, violence, suicide and alcoholism . . .

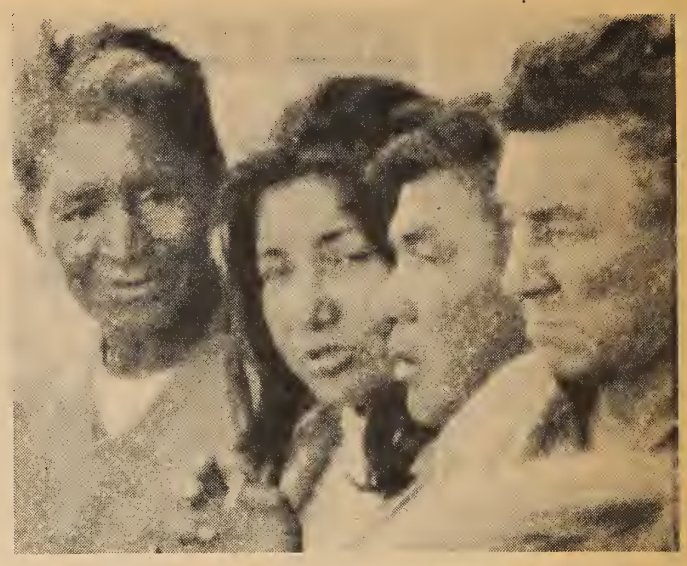
"Another theory suggests that the lives of many Indian people are without meaning. . . . A third theory is that white attitudes toward Indians are discriminatory and that these prejudices and biases become self-fulfilling prophecies . . .

"A fourth theory is that Indian communities are more loosely controlled than white communities, that an Indian person will not intervene in the affairs of another Indian (and that) communities are more tolerant of deviant behavior . . .

"A final theory holds that adequate social services are unavailable to Indians . . .

"Most Indians drink, as do most Canadians generally. Drinking is an acceptable social custom and a majority of the adult population drinks — about 70% in both Indian and white populations.

"While intoxicated, the behavior of Indian people is basically the same as that found in other groups of the population. Whatever differences do occur appear to be the result of sociological factors and not racial factors."



Waiting in the growing liquor store line-up

Schools/media prevention scapegoats

(Continued from page 1)

completely different from asking people to give up their long-established drinking patterns without guaranteeing any immediate short-term gains.

"It is naive to expect that such short-lived campaigns can do much to change deep-seated attitudes and behavior concerning drinking".

He said it is unlikely there will be much done to reduce alcohol problems "until there springs up a genuine social movement toward moderation that enlists the energies and hopes of large numbers of people on the grass-roots level."

He said prohibition had been such a genuine movement. "It gained widespread support among the rank and file of American people for many generations because it filled a perceived need.

"While I would be against the return of prohibition both because of its apparent unworkability in its later stages and because of the class divisiveness and cynicism it brought about, I do deeply feel that only a large-scale social movement would provide the person-to-person evangelizing that could crystallize the social norms which would enforce moderate drinking behavior on an informal, yet effective, peer-pressure basis."

He said there are two indications such a social movement toward moderation might work. "One is that an overwhelmingly large proportion of Americans pays at least lip service to the concept of moderation, and high proportions feel guilty or uneasy about their own or their significant others' heavy drinking."

Another indicator is the existence of several cultural groups within the US with quite a consistent track record of moderation in the use of alcohol — particularly such groups as the Jews and Chinese. Most of them drink, he said, but relatively few have drinking problems.

"I strongly believe moderation is directly related to setting a good parental and peer-group example at home and in other social situations."

Tobacco manufacturers volunteer

Advertisement clean-up in UK

LONDON — Those brave and sexy young people who have been smiling out from billboards and books for years inviting Britons to take up or stay with the cigarette habit are no more . . . not in advertisements at least.

Just one week after the government announced it was considering tough new controls over the tobacco industry, the manufacturers drew up their own voluntary code of advertising guidelines.

From now on, all print media will be asked not to accept ads that violate any of the basic guidelines set out in the code.

The code specifically forbids:

- Copy or illustrations that are sexually titillating or which imply a link between smoking and sexual success;
- Claims directly or indirectly that to smoke or to smoke a particular brand is a sign or proof of manliness, courage or daring;
- Any testimonial for or recommendation of the product by any well-known person of distinction in any walk of life.

It also forbids use of such words as "clean" or "pure" to describe a brand; emphasizes that smoking and youth should not be linked; and says people shown in advertisements should be clearly more than 25-years-old.

The code was drawn up by the manufacturers and the British code of advertising practices committee. An independent watchdog body, the Advertising Standards Authority, began supervising it on Sept. 1. It is expected to be fully operational within six months.

Authority chairman, Lord Drumalbyn, said the new ad models will not necessarily be "a lot of puny creatures".

Of ads depicting smokers as healthy, sporty and attractive, he said: "All those things are so much a question of emphasis."

Cigarette commercials have been banned on television here since 1965 although commercials for pipe tobacco and cigars are still shown and will continue to be under the new guidelines.

In the earlier announcement of the government's intention to introduce new, tougher laws, Dr David Owen, health minister, said the way tobacco products are made and promoted "must be subject to the same considerations as other drugs of addiction which can be dangerous to health".

An independent pressure group, Action on Smoking and Health (ASH) called the new voluntary code "welcome and overdue but grossly inadequate".

Mike Daube, ASH's executive director, said it will affect only some direct cigarette advertising and not sports sponsorship, coupon schemes, cigar advertising, or other indirect forms of cigarette promotion".

The Department of Health also complained the code does not go far enough.

* An estimated £70 million each year is spent on tobacco advertising, sponsorship (of mainly sports events) and promotion. The Government's Health Education Council, in contrast, spends £ 200,000 on anti smoking campaigns.

. . . But gov't forced the move

LONDON — The British government's decision to take a tougher line against tobacco manufacturers came after months of negotiations between health minister David Owen and the tobacco industry.

Dr Owen said the negotiations had made "only moderate progress".

In effect, the government decided that the way tobacco products are made, sold, described, and advertised must be subject to the same considerations as other drugs of addiction which can be dangerous to health.

It warned manufacturers of tobacco products that they face the prospect of cigarettes and cigars being subject to sale under licence.

Alternatively, however, Dr Owen told the House of Commons that manufacturers would have to introduce voluntary moderations of their advertising and promotion. One week later, the industry responded with its voluntary code of advertising guidelines.

Dr Owen said successive governments had been unsuccessful in negotiations with the tobacco industry and he believed this was in part because arrangements for bringing independent medical and scientific evidence to bear upon the industry needed statutory backing.

The government believed this could be achieved by treating tobacco like other addictive substances covered by the Medicines Act 1968. Under this act restrictive action on the sale of a product could be taken on advice from an expert and independent advisory committee.

Dr Owen said that control would be exercised over tobacco so as to influence the use of substitutes and additives; reductions in the yields of tar, nicotine and carbon monoxide; and the publication of health warnings and information on advertisements. It would also be possible to restrict promotion and establish codes of practice for advertising and sponsorship.

The Minister said the government will make proposals to Parliament about further action when it has concluded talks with the industry, the Medicines Commission and the Committee on Smoking and Health.

To a large extent, credit for this initiative from Dr Owen should go to the Royal College of Physicians pressure group Action on Smoking and Health, which has conducted an energetic campaign to restrict the sales of tobacco.

Chafetz joins Johns Hopkins

WASHINGTON — Dr Morris Chafetz, who steps down as director of the National Institute on Alcohol and Alcoholism this month, has accepted a research post with Johns Hopkins University.

Dr Chafetz, NIAAA director since its inception in 1971, will become principal research scientist at the Center for Metropolitan Planning and Research at Johns Hopkins.

He will hold an academic rank equivalent to full professor, but will not teach. He said he will engage in writing, lecturing, consulting and planning in the health field.

His activities will range beyond the area of alcoholism, with which he has been associated for 23 years.

In his letter of resignation, Dr Chafetz noted that when he entered the public service he intended to serve no more than five years.

During his service in the federal alcoholism campaign, he said: "We have made great and important strides — accomplishments beyond our fondest dreams of what we believed was possible.

"The framework is in place throughout this nation for a humane and effective relief from the tragic losses alcohol abuse and alcoholism cost us as a people."

Dr. Chafetz' successor as director of the NIAAA has yet to be named.

'But it's a monumental job'

LA scheme for gay women going well

By SAUL ABEL

LOS ANGELES, CAL. — The first comprehensive program for gay, alcoholic women in the nation, one year after its inception, is alive and well in Los Angeles.

Located on the edge of the central city in two rambling houses that date back almost to the turn of the century, the Alcoholism Program for Women (APW) is tackling a job of monumental proportions.

The problems of alcoholism, complex and difficult enough in themselves, are compounded in women. With the added complications of lesbianism, they might well appear insoluble. But not to APW director Brenda Weathers, a former social worker, x-ray technician and antique shop owner whose deceptively quiet voice and manner hide an inexhaustible supply of energy.

"We recognize the difficulties we face, we know there is so much to be done and we can't do it all," Ms. Weathers told **The Journal**, "but we've mobilized a lot of energy and a lot of concern.

"I believe we're building a strong, workable program, a demonstration project that can point the way for others."

A few scattered programs for gay, alcoholic women exist in other cities, but they are much more limited in scope, she said.

Herself a recovered alcoholic, 38-year old Ms. Weathers experienced a traumatic expulsion from college at age 19 for lesbianism. She later went on to earn a degree in anthropology and sociology. In 15 years as a "practising" alcoholic, she found virtually all alcoholism facilities oriented toward male clients and virtually all alcoholism agencies reluctant to accept gay women.

Some help was available from the Gay Community Services Centre of Los Angeles, but she became convinced of the "desperate need" for a program specifically designed for gay alcoholic women.

Her intense concern eventually produced a detailed proposal to the National Institute on Alcohol Abuse and Alcoholism, and a grant of approximately $340,000 for the first year of a three-year program.

Approximately the same sum has tentatively been earmarked for each of the next two years.

Currently, there are more than 100 participants at APW, ranging in age from 19 to 58 years. Most are white, working class women in their early 30s.

A sing-song on the steps of APW

About two-thirds are gay, about one-third non-gay. APW services are available to all women, though the special emphasis and concern is for the lesbian alcoholic and her specific needs and problems.

Eleven participants are residents in the recovery house, which offers the same full range of information and education services, self-development activities, vocational rehabilitation, and job placement services.

Non-medical detoxification is also available in the recovery house, patterned on the social model, with no drugs or medication. The only requirements for admission are willingness, and 24 hours of sobriety.

Most alcoholism rehabilitation centres expect a 25% sobriety rate by the end of a year, Ms. Weathers noted. One group at APW has attained a 75% sobriety rate after six months. It is too soon to know if this will be maintained, but it is encouraging, she said.

Outreach programs are among the most active at APW. Speakers go to schools, colleges and other community locales talking about the problems of alcoholism and also working to dispel the common myths about gay women.

One such myth is that all lesbians are masculine in appearance, wear masculine clothing and act like men. APW speakers often show slide presentations to demonstrate that gay women are all ages, sizes, professions, classes, colors and from all lifestyles.

Another common misconception is that gay women are bizarre sexual creatures, given to whips, boots and other erotic deviations. This is a stereotype perpetuated in pornographic literature written by non-gay men for non-gay men.

A third myth pictures gay women as child molesters. Statistics prove conclusively that most child molesters are men, and moreover they are non-gay men, said Ms. Weathers.

Through every facet of APW activity runs a basic theme; to cope with the alienation, isolation, and despair experienced on a day-to-day basis by gay women in a male, heterosexually dominated society.

Ms. Weathers cited three "dangerous dynamics" produced by such oppression, alienation and loneliness.

1. Failing to identify the needs, problems and concerns of gay women alcoholics;

2. Delaying the search for help by gay women alcoholics; and

3. Allowing thousands of gay women alcoholics "to puke and suffer their way to insanity and death without benefit of prompt, relevant and adequate treatment".

Roses, Hollyhocks and Pot

--In an English country garden

By ALAN MASSAM

LONDON — The heatwave coupled with a crackdown on imported pot by customs officials will mean a bumper crop of home-grown cannabis plants in Britain this year.

But Scotland Yard's drug squad is not taking the horticultural skills of hundreds of young illicit gardeners too seriously.

Despite the suitable weather for maturing the cannabis plant (temperatures in London were well over 90 deg F — higher than those of New York — last month) a detective explained: "The quality of the drug grown in London back gardens is very poor."

The police are giving the young growers full marks, however, for trying. Some have transported cannabis seed to quiet country fields for sowing alongside corn crops.

The idea was to harvest the plant secretly when it became mature. Farmers, who have their minds concentrated on other things at this time of year, were not expected to recognize the cannabis plant when they saw it.

The possibility, however, that they might spray the curious weed with a powerful weedkiller doesn't seem to have occurred to the clandestine planters.

Perhaps the most serious response to the home-grown cannabis craze has been from police in the university city of Cambridge.

A spokesman said: "No longer are some people content to scatter the seeds and leave nature to take its course. It now appears that plants are raised indoors for planting out at a later stage."

Cambridge police estimate they have spotted a few hundred cannabis plants growing in gardens in the city during the past year.

Cannabis resin is currently being sold on the British black market for about £35 an ounce, so there is some incentive for students to persevere with their horticultural efforts!

Alcoholism counsellors

Certification confusion is clearing

BURLINGTON, VT.—The battle to certify the competence of alcoholism counsellors is well under way despite confusion over standards and the dilemma of "the do-gooder who is not qualified", according to an American expert.

John W. North told a meeting here: "Alcoholism must move into the mainstream of health care in order to enjoy the benefits of established respectability and to secure a fair share of public and private funding".

At the same time, certification is necessary to maintain and enhance the integrity of the alcoholism field, he said.

Mr North, who is project director, certification/accreditation, Council of State and Territorial Alcoholism Authorities, was speaking at the 1975 New England School of Alcoholism Studies.

The only issue now, he said, is present and future money.

"You are going to be asked what kind of results your expenditure has produced? And with respect to future money availability, the question is going to be: How is the quality of your product (alcoholism care) assured?

"One measure of that quality is the competence of your program's people. Therefore, we need standards to define what one needs to know and what one must be able to do".

He said confusion surrounding the question of standards was understandable.

A report entitled Proposed *National* Standards for Alcoholism Counsellors was prepared by Roy Littlejohn and Associates and submitted to the *National* Institute on Alcohol Abuse and Alcoholism (**The Journal**, Dec. 1, 1974).

Despite the recurring word "national", however, the responsibility for setting standards rests at the state level, said Mr North.

"Much of the confusion resulted from failure to pay attention to the definitions or distinctions spelled out in the Littlejohn Report.

"Certification as proposed in that report was to be a VOLUNTARY system, providing alcoholism counsellors with a certificate indicating or recognizing professional competency. The report states:

'Certification systems may be based on a standard or set of standards controlled by a profession, an employer, or a State authority. The two latter types . . . are mandatory *systems applying to all practitioners falling under the jurisdiction of the particular systems'.*

'It is a part of the total responsibility of each State to establish regulatory standards and procedures to assure quality in the delivery of health care services. The authority for such activity is to be found in the statutes of the States'."

So far, he said, only a few states have established systems of certification/licensure of alcoholism counsellors although voluntary associations of counsellors are active in many States.

"On the other hand, many States currently have regulations and standards and are licensing alcoholism treatment facilities. The Joint Commission of Accreditation of Hospitals has published their first report on programs that have been accredited".

Mr North explained the Littlejohn Report contains a "grandfather" clause which would make it possible to certify without examination an estimated 5,000 to 10,000 present alcoholism counsellors on experience.

"The treatment of alcoholism has developed uniquely outside the professional settings and some of the most effective treatment of alcoholic persons is provided by individuals without degrees in traditional health care disciplines".

This makes the issue complex and emotionally loaded and the setting up of criteria for competence becomes a case of who, what, where, when, why, and how, within a multiplicity of settings, he said.

Nonetheless, the need is pressing to identify skills of the alcoholism counsellor in order to make him a partner in the health care system "without having to sacrifice the special contribution in philosophy, techniques and humaneness that have made it possible for so many to escape the enslavement of their addiction".

He explained that the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970, amended in May 1974, requires for fiscal year of 1975, that as part of its State Plan requirements to qualify for formula grant funds, each State "set forth in accordance with criteria to be set by the Secretary, standards for a) construction and licensing of public and private treatment facilities and b) for *other community services or resources* available to assist individuals to meet problems resulting from alcohol abuse".

This means, Mr North said, that the State and the federal governments have an immediate responsibility for standards.

New service for Quebec

MONTREAL — Although *l'Office de la prévention de l'alcoolisme et des autre toxicomanies* (OPTAT) now exists in name only in Quebec, a new service is being developed in Quebec's department of social affairs.

Jean-Claude De l'Orme, former head of OPTAT's research service, has been appointed *Chef de Division*. He will have prime responsibility for planning and programming in the drug and alcohol abuse fields for all of Quebec. He will report to assistant minister of social affairs, Aubert Ouellet.

"We have to work with the department of education as well," De l'Orme told **The Journal**, "and concepts can be conceived on that end."

De l'Orme's first task lies in preparation of a major policy report for the department of social affairs on prevention, treatment and rehabilitation in the drug area. It will cover prescription drugs as well.

With his staff, which is as yet small, he looks forward to the "enormous task".

They must plan and evaluate programs for the 10 administrative health regions of the province under the master health plan initiated by former minister of social affairs, Claude Castonguay.

The Castonguay Plan sees community services centres as key elements. It is to these centres that the addict, drug abuser, or alcoholic will go for first line treatment or referral. De l'Orme and his staff will have to decide how policies formulated at the governmental level can be applied and realized at regional levels.

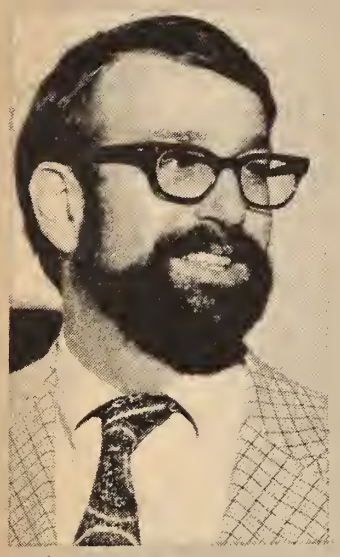
"Nine of these community services centres are now in operation," De l'Orme said, "but over 20 are projected."

As reported earlier in **The Journal**, however, these centres do not as yet have the specialized personnel needed to treat addictions or drug abuse.

Also underway, said De l'Orme, is an evaluation of various federally-financed non-medical use of drugs programs.

Abstinence must be the target

ABSTINENCE, not controlled drinking, should be the primary treatment objective for all clinicians dealing with alcoholics, according to the director of the Alcohol Behavior Research Laboratory, Rutgers University.



Peter Nathan

"That is my view at this point and on the basis of the data available," keynote speaker Dr Peter Nathan told the conference. He recognized: "I have strong disagreement with (some) others in the field.

"Also, on the basis of data available, we cannot now nor perhaps will we ever be in a position to say to the alcoholic who has been sober: 'We can now offer you the opportunity to return to drinking and help you be a controlled drinker'.

"We do not have that ability. Anybody who tells you that we do is a liar."

On the other hand, he said, many alcoholics have tried to achieve abstinence repeatedly over the course of a very lengthy drinking history and have failed.

"In my view, again based on the data we have available, it may be that efforts to teach controlled drinking for these people may be more efficacious than seeing them continue a pattern of uncontrolled drinking.

"In this case, less drinking is better than more drinking. It is probably not as good as no drinking," said Dr Nathan, also professor of psychology at the New Jersey university.

Having stated his position, however, Dr Nathan added: "I think the data suggest that we have some reason to continue to pursue these treatment goals.

"What we don't know are the kinds of people for whom abstinence, the kinds of people for whom controlled drinking, as therapeutic goals, are most useful.

"For all we know we may find some years down the road that controlled drinking is inappropriate for everyone. Or, we may find that controlled drinking training may be more useful as an additional treatment strategy than other kinds of treatment strategy.

"But what we don't know now is the basis on which to make these decisions."

Until recently, he said, treatment was based on the premise that the only goal for alcoholics was total abstinence.

"This whole treatment aim stemmed from the widely held conviction that alcoholism is a progressive, irreversible disease characterized by loss-of-control drinking during drinking, and a profound craving for alcohol during sobriety.

"The belief that a single drink by the dry alcoholic inevitably leads to loss-of-control drinking has been reinforced through the years by Alcoholics Anonymous which considers total abstinence to be its only treatment goal."

However, he said, several investigators have recently challenged this orientation, demonstrating "that one drink or several does not always unleash irresistible craving and loss of control over drinking".

Other researchers have reported that voluntarily, chronic alcoholics will choose to drink moderately despite the availability of large quantities of alcohol in order to live in more desireable situations.

"It seems clear to these researchers that alcoholics can moderate their drinking given certain environmental alterations."

Still other investigators, he said, have observed that some alcoholics in fact seem to return to moderate levels of drinking even after little or no specific therapeutic intervention.

"I think it is important on the basis of what must be considered admittedly preliminary outcome data that controlled drinking may well be an appropriate treatment objective for some individuals but an inappropriate treatment objective for many others."

On these two pages, ANNE MACLENNAN reports from a converence on Behavioral Approaches to Alcoholism and Drug Dependencies held at University of Washington, Seattle.

ATTITUDINAL CHANGES ARE A MUST

THE VALUES and attitudes of problem drinkers must be changed or there will be no dent made in improving the treatment of alcoholics, says Dr Don Cahalan.

People with severe drinking problems are preoccupied with what alcohol will do for them. They have the attitude their lives would be even emptier without it, he said.

While many in the field recognize that attitudes to alcohol play a paramount role in future behavior, "too many of us are hoping for some magic treatment that ultimately will 'cure' the alcoholic without requiring a basic change in his values and attitudes.

"I am certain that unless we keep those with drinking problems locked up, we cannot expect them to stay moderate drinkers or abstainers without changing their attitudes about the importance of alcohol in their lives.

"No matter how much we try to tinker with their personalities or their environments, they will find a thousand reasons to revert to their old drinking habits, unless and until they learn that alcohol is worth less to them — both short-term and long-term — than other considerations in life."

Dr Cahalan, professor of behavioral science and director of the social research group, School of Public Health, University of California, Berkeley, entered the field of alcoholism studies as a survey research specialist with a background in many types of social-psychological studies of human behavior.

He referred to the findings of the recent Stanford Research Institute study on the presumed effectiveness of federally-funded alcoholism treatment centres.

It found that IF the client stayed in treatment as long as 18 months, his chances of showing improvement were approximately 70%, no matter what specific treatment methods were used.

"However, the catch is to get the client to STAY IN treatment for long enough to improve both his health and his values concerning alcohol because a very large proportion of persons who are referred to treatment agencies fall by the wayside because of lack of motivation — which I think must be attributed largely to being unwilling or unable to modify their attitudes as to the importance of alcohol in their lives."

Therapy is now more realistic

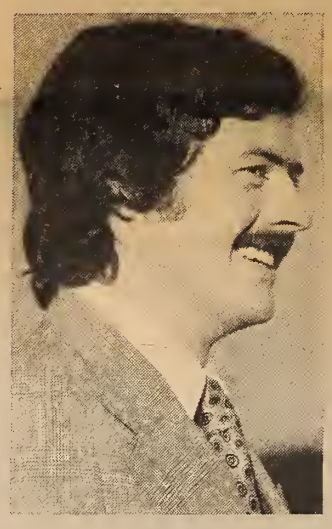
TREATMENT PACKAGES tailored to the specific needs of various alcoholic populations are becoming an increasingly realistic goal with the developing sophistication of behavioral therapy techniques.

This is the opinion of Dr Peter Miller, associate professor of psychiatry and human behavior, University of Mississippi Medical Centre, and director, Alcoholism Unit, Veterans Administration Centre, Jackson.

He said behavioral approaches to alcoholism are neither simple nor new: References to the use of aversive conditioning date back to 1928. And in the past, interpretations of strategies have been "grossly oversimplified and misunderstood".

Historically, he said, widespread use of aversive conditioning was based on two assumptions. One was that chronic alcohol abuse could be explained primarily in terms of a simple conditioning model. The second was that since electrical and chemical aversion conditioning had been demonstrated to be effective in suppressing simple motor responses in animals and humans, they should also be effective in modifying drinking responses.

"Unfortunately, present experimental data do not support a simple conditioning explanation of alcoholism. In addition, on the basis of current evidence, direct application of aversion therapy from animal laboratories to clinical situations appears to be a rather naive treatment strategy."



Peter Miller

Thus, behavioral therapists are now taking "a more realistic view of alcoholism and its treatment".

"Contemporary behaviorists espouse an empirical rather than a theoretical orientation which takes the form of a descriptive-explanatory model based on a functional analysis of drinking behavior."

They see abuse drinking as being related to a wide variety of specific antecedent and consequent events of a social, emotional, cognitive, environmental, or physiological nature. Any one of these factors, or a combination of them, may precipitate alcohol abuse.

He said exact combinations of events related to drinking at any one point in time may be highly complex.

"Much research has been devoted recently to an examination of the effects such factors as social stress, visual alcohol cues and social pressure have on the drinking behavior of alcoholics and social drinkers.

"The major point here is that a steady body of knowledge based on DIRECT OBSERVATIONS of alcohol abuse and events associated with it, is being accumulated.

"This is a definite step in the right direction toward the establishment of a viable set of treatment packages designed for various alcoholic populations such as *skid-row, females, etc.*"

He said a necessary future trend in behavior therapy with alcoholics must be development of procedures for the long-term maintenance of treatment effects.

"My own bias is that for treatment to last over a period of time, the alcoholic must be provided with the social and self-management skills necessary to maintain a new pattern of life, together with an environment designed to support behavior change.

"At present, a comprehensive behavioral approach, including a variety of therapeutic techniques, for example assertive training, operant strategies, marital counselling, employer contracting, appears to be most useful.

A problem in behavior therapy

Techniques often too readily accepted

CHEMICAL AVERSIVE conditioning may not even be necessary but it must be explored, Dr G Terence Wilson of Rutgers University told the conference.

"It's vital that we do controlled studies isolating its effects to see whether in fact it is necessary.

"If we are going to use that procedure we want to know whether it is necessary, whether it adds anything to more benign procedures.

"I am not sure it would ever be necessary even if there is evidence that shows it is a clinical approach that will work. I am not at all sure it will be necessary to use it. There might well be alternatives. We need to explore this."

He said "one interesting finding" recently is that "behavioral therapists are at last becoming aware that in addition to reinforcers, people have genes and chromosomes and there are genetic differences".

It has been noted that there are individual differences in rats in the development of conditioned aversive reactions. And it has been suggested this may also apply to alcoholics, that there may be some who are otherwise normal but who do not develop conditioned aversive reactions.

"Whatever the basis is for these individual differences, they need to be uncovered and perhaps that would be an important predictor variable for behavioral treatment.

"At this point in behavior therpay, we have no good predictor variables for any technique for any problem.

"Matching treatment technique to individual problems is still really a matter of informed guesswork and trial and error, than a very logical scientific process as hopefully it will sometime be."

He referred to studies of electrical aversive therapy and said interpretation of most is clouded by the particular outcome research strategy employed. He dismissed it as contraindicated as a clinical procedure.

As for covert sensitization in which patients are asked to imagine aversive consequences contingent on consuming alcohol, he said there have been a "a few uncontrolled clinical reports".

"If you look carefully at the results, they are highly unconvincing.

"To generalize slightly, I think this is a problem we have in behavior therapy today. I think there is too-ready acceptance of the efficacy of many behavioral techniques without sufficiently searching experimental analysis data.

"Covert sensitization is a prize example. Many articles assume it works with alcoholics and many problems. But, careful review of the literature indicates really no compelling support for this technique with any problem other than perhaps with some form of sexual deviation but certainly not with the addictive behaviors."

He urged continued research of the method, however, "particularly as it might be combined with chemical aversion to produce maintenance of initial chemical aversion."

Terence Wilson

Social drinker may follow lead of heavy-drinking companion

SOCIAL DRINKERS may subconsciously increase or decrease the amount of alcohol they consume to fit the pattern set by their drinking companions.

This is suggested by a study at the University of Washington to determine the effects of social modelling influences on drinking behavior.

Chief result was that heavy drinkers exposed to a high-consumption model — i.e. another person drinking quickly and thirstily — consumed significantly more alcohol than subjects paired with low-consumption models.

The study, by Drs Barry D. Caudill and G. Alan Marlatt, was described by Dr Marlatt, associate professor of psychology.

He said that while the study was "primarily exploratory", the findings indicate a modelling effect can be demonstrated in an analogue drinking task in which social drinkers are exposed to the drinking behavior of another individual.

"Modelling influences need to be investigated in a variety of field settings in order to test the generalizability of these findings.

"Naturalistic observations of drinking behavior in social settings such as bars, parties, and other common drinking situations would provide a wealth of information on this issue," he said.

In the study, subjects were 48 male students, all heavy social drinkers, to whom the experiment was described as a test of their taste discrimination ability. They were assigned to one of six groups on the basis of two factors to be tested.

The first factor consisted of three modelling conditions: exposure to a "heavy" consumer model; to a "light" drinking model; and to a no-model control condition.

For the second factor, subjects engaged in a brief "social interaction" prior to the test, with a model who played either a warm or a cold emotional role.

Modelling effects were assessed in a laboratory wine-tasting task in which both subject and model participated together.

Subjects were all presented with three decanters containing 700 ml. each of three different wines, and three empty glasses. They were asked to rate taste on the basis of a selection of adjectives provided and were free to sample as much of each beverage as they wished in the 15-minute testing period.

In the high consumption group, the "confederate" took large sips of wine, frequently refilled his glasses, and drank a total of 700 ml. or the equivalent of one full bottle.

In the low-consumption condition, the confederate took smaller sips and consumed a total of only 100 ml. in the same period. In the no-model control, the subject performed the "tasting" task by himself.

Results showed exposure to a heavy drinking model had a significant effect on the observer's drinking behavior in terms of the total amount of wine consumed, the number of sips taken, the amount consumed per sip, and the final blood-alcohol level.

There was no significant difference between the light drinking model and the no-model condition possibly because subjects in the two groups kept close to the minimum consumption level required for successful participation in the taste-rating task.

The prior interactions did not affect drinking behavior. Dr Marlatt suggested a "parsimonious explanation" for this failure to find a significant effect may be that "the modelling influence alone was so strong that it overshadowed any effects associated with the prior relationship between model and observer".

Dr Marlatt (on right) with Dr John Ewing of University of North Carolina

Prototype suggested

Outcome evaluation required

Dr Peter Nathan and Drs Linda and Mark Sobell in Seattle

ONE OF THE MOST significant areas in the field of alcohol studies is perpetually ignored, claims Dr Linda Sobell.

"Treatment outcome evaluation allows us to determine whether a treatment technique or program actually is generalizing to the client's environment or the real world," Dr Sobell told the conference.

"Is what we're doing in the laboratory and treatment programs going to work and for how long? That's what we're talking about," said Dr Sobell, director of alcohol programs, Dede Wallace Centre, Nashville, Tennessee and one of the first, with Dr Mark Sobell, her husband, to consider controlled drinking as a treatment option to abstinence.

At best, she said, outcome evaluation is "in its infancy".

"We've developed some nice measures recently but we don't know what they mean.

"We often evaluate marital status for subjects. So, what does the changed marital status from marriage to divorce mean? Does it mean a person is doing better or doing worse? We don't know.

"With respect to evaluating controlling drinking data, it becomes difficult to draw other than arbitrary (conclusions) about how drinking approximates normal drinking. We have a very few population norms. We don't know what controlled drinking means."

She warned that outcome evaluation should not be viewed as a panacea for poor treatment success rates.

"I think all it will do is provide us with the necessary directions in which to develop better treatment programs and projects.

"It must be recognized that major errors in design of treatment evaluation, the collection of data, and the interpretation of that data, can destroy good programs and perpetuate bad ones.

"Treatment evaluation can be an extremely important instrument. But, if used carelessly, it can do more harm than if not used at all," she said.

She outlined a suggested prototype for performing adequate treatment outcome evaluation in the alcoholism field:

PRE-TREATMENT MEASURES

- pre-treatment measures are necessary to adequately measure and interpret treatment outcome data;
- measurement before and after treatment should cover the same time period and be designed for comparability;
- measures should be standardized across subjects;
- follow-up tracking data — information which is necessary for contacting and following subjects and their respective collaterals over a long period of time should be obtained BEFORE the subject's discharge from a treatment program;
- evaluation should be PLANNED prior to the actual treatment stage.

TREATMENT OUTCOME MEASURES

- adequate definition of criterion variable;
- measures should be continuous and quantifiable (i.e. number of days missed work rather than majority of the interval employed);
- multiple measures of outcome should be used (i.e. drinking behavior as well as other measures of life functioning);
- data should be presented for individual subjects as well as groups;
- predictors of varying levels of treatment outcome should be developed for each modality.

FOLLOW-UP PROCEDURES

- brief subjects PRIOR TO discharge about the nature of the follow-up to be conducted i.e. reasons for, type, frequency, and duration of interviews;
- equal follow-up intervals for all subjects;
- frequent follow-up contact: "It is suggested that such contacts can gather more sensitive outcome data and ensure a higher follow-up retrieval rate." She suggested that frequent follow-up contacts may have a continuing care process.
- use of multiple collateral information sources to verify self-reports;
- use of record data to verify all quantifiable self-reports;
- do not combine data from difference sources.

QUESTIONING SELF-REPORTS: A BELATED VOGUE

THE CURRENT fashion for questioning the validity and reliability of self-reported data from alcoholics is 40 years late, Dr Linda Sobell told the conference.

She said she became interested in the subject because it "is becoming vogue to question self-reports now that controlled drinking studies are around".

(Dr Sobell and her husband, Dr Mark Sobell, were among the first to suggest that controlled drinking for alcoholics might be a realistic treatment goal.)

"I am really sorry we did not address this issue before because the last 40 years of alcoholism research have also used self-reported data. All of us use self-reported data."

However, she said: "If we have controlled drinking to thank (for the fact people are questioning it) then thanks for that."

She stressed that self-reports are used for more than outcome evaluation — they are used in making diagnoses and making treatment decisions.

"Many of the kinds of things we do are based on self reports. If we are going to have caution, then it must apply to every area where self-reports are used, not just as it applies to controlled drinking."

She said while self-reporting may be more reliable than is often thought, there are ways of "tapping into more valid self-reports".

She suggested workers corroborate subjects' self-reports with reports from other reliable sources of information such as friends, employers, family.

In-field breath samples of subjects' blood alcohol content concentration is another method as is comparing self-reports to official records of hospitalization, arrests, employment.

"We would also lose more subjects to follow-up if they don't know who is going to be contacting them.

"We don't know. I am suggesting until we know, that we used skilled, knowledgeable interviewers who know how to do interviewing."

Alcoholics may need to be trained to express negative feelings

TRAINING ALCOHOLICS to express negative feelings may be more essential to therapeutic success than teaching them positive assertiveness, says Dr Peter Miller of the University of Mississippi Medical Centre.

Describing assertiveness as the appropriate expression of personal rights and feelings, Dr Miller said several clinical and experimental studies have indicated personal situations requiring assertiveness are stressful for alcoholics and frequently set the occasion for excessive drinking.

In a study in the department of psychiatry and human behavior, Dr Miller evaluated three issues related to this deficiency: the relationship between alcoholics' self reports of their assertiveness compared with actual assertive responding; the relationship between alcoholics' assertive responding and drinking behavior; and the assertive behavior of alcoholic patients as compared to non-alcoholic patients receiving psychiatric treatment for other problems.

The 10 alcoholics scored significantly higher on the self-report measure than did the 10 non-alcoholics. Alcoholics and non-alcoholics scored equally low in their ability to express negative feelings. However, alcoholics scored significantly higher on the expression of positive feelings.

There was also a statistically significant negative correlation between negative assertion and drinking on the operant task. Thus, the less assertive an alcoholic was behaviorally, the more alcohol he was likely to consume.

The results appear to have two implications, said Dr Miller.

Clinicians must be wary of exaggerated self-reports of assertiveness by alcoholics when establishing treatment goals and assertive behavior should be assessed directly or via reports from others.

Second, training in expression of negative feelings for alcoholics may be more important than training in positive assertiveness.

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Time to count the cost

THE PROVINCE of Ontario is in the midst of an election campaign, yet hardly a voice has been raised to demand some action to curb the growing social impact of alcohol abuse.

The statistics are clear and becoming clearer by the day: The health and social costs of alcoholism are running more than $135 million a year in this province; alcohol-involved traffic collisions are adding another $130 million; alcohol has been implicated in more than 40% of boating drownings, and in one of every two auto deaths.

Soon, liver cirrhosis — almost half of it of an alcoholic origin — will become the fourth highest cause of death of young and middle-aged males in the country.

Since the lowering of the legal drinking age to 18 years, evidence has accumulated showing the deleterious effects of heavy drinking on growing numbers of teenagers.

In one Ontario city, the year after the lowering of the drinking age, 18-year-olds were involved in 300% more traffic collisions than in the previous year, and 19-year-olds in 348% more.

In concert with this trend, the alcohol merchandising forces continue to step up their activities, the ultimate goal appearing to be nothing short of saturation.

In the recent past it has not been popular to speak out against liberalization of controls governing the sale and distribution of alcohol. Certainly, when legislation extending the right to drink to all persons over 18 years was introduced, there were few voices of protest. But the results of that action are now coming home to roost.

Some jurisdictions have expressed concern that lowering the drinking age has produced more problems than anticipated. And they are now considering reversing their earlier permissive legislation.

Whether or not that is possible, politically, can not be determined until the issue is aired publicly. Certainly, however, it should not be immediately discounted. It deserves a good and thorough discussion.

Perhaps there were mistakes made when the law to lower the drinking age was invoked. But, it might be a bigger mistake not to examine the results of those actions in the light of subsequent experience.

There now seems some evidence that people themselves are becoming concerned about the extent to which alcohol is impinging upon the nation's health. There is some indication of public support for a policy that would provide more judicious control of a drug that, when used immoderately, has the potential for great harm. There are several courses open to the social policy-maker concerned about the growing abuse of alcohol. All of these should be thoroughly investigated.

But at the very least, a moratorium should be placed on further moves to liberalize the sale and distribution of alcohol, until the public has a clear and cogent picture of exactly what that liberalization is costing, in terms of money, and in terms of human suffering.

Politicians usually have the knack for seeing which way the mainstream is heading and then charging out front to "lead".

This may be one of those times when a little imagination, and a certain amount of guts, may put the campaigner out at the head of that crowd.

The national beginning

UNQUESTIONABLY, it was politically astute of the Canadian Foundation on Alcohol and Drug Dependencies to call together Canada's first national consultation on alcohol and drug abuse among women.

It is still, after all, International Women's year and the CFADD is looking for, and indeed if it is to remain alive, needs attention and the new members that come with it.

That said, however, CFADD must be heartily congratulated for having made a critically necessary national beginning in this area of looking at women and addictions. None but the very lonely heart could say any more that women do not have some very special needs peculiar to them and them alone in this area.

This national beginning, however, could so easily prove also to be the national end — at least until someone else tries again.

Delegates to the consultation have done, for the moment, what was asked of them. They came to the meeting, they worked, they made recommendations. Now they have gone back to their own provinces. No doubt most were pleased to make new acquaintances and renew old ones but some will be sceptical that anything more positive than that will result from the week-end.

So the onus is left, and it is not a light one, with CFADD. Having bitten into the problem, it may well now feel its eyes were bigger than its stomach.

CFADD has its own image and survival to consider and its own annual meeting coming up this month.

At the same time, it has more recommendations aimed at improving approaches to women alcoholics and drug abusers and the field in general, than it had delegates at its special consultation.

We wish it best of luck in the three areas but urge it not to let the question of women's needs get lost once again.

— AM —

Letters to the Editor

Sir:

Given recent estimates by the Drug Abuse Council that 29 million Americans have tried marijuana, it is certainly proper, indeed imperative, to assess the psychological and physiological impact of such use. To this end, millions of dollars have been spent on a great variety of research efforts that began in earnest in the late 1960's. Unfortunately, two factors have clouded the utility of much of this research.

In the first place, the political/moral symbolism attaching to marijuana use has compromised the objectivity of more than one research project. Experiments frequently are designed not to measure the effects of marijuana on well-defined areas of interest, but rather to demonstrate that marijuana causes such things as lack of motivation, memory loss, paranoia, violent or unpredictable behavior, brain damage, liver disorders, heart degeneration, impotence, reduced resistance to disease, etc. The list is almost endless. Consumers Union noted (March 1975) that despite many years of recent research based on demonstrating the deleterious effects of marijuana use in humans, not a single study has been replicated successfully that substantiates these claims.

The second area of concern is really an outgrowth of the first in that the lack of easily demonstrable pathologies calls for either a change in belief or a change in methodology.

Unfortunately, most of the change seems to be aimed toward more intensive and (presumably) more sophisticated research methods whose real purpose is to vindicate our social and legal policy on marijuana for the last 40 years.

One of the most misleading and pernicious trends in research designs is the use of enormous doses of pure THC (the active component in marijuana). Frequently, this results in situations such as a study reported by the National Commission on Marijuana and Drug Abuse in which primates were given (and survived) daily injections of THC in amounts 100,000 times the behaviorally effective dose. Translating this into doses and drugs that all are familiar with, one hundred thousand times the effective dose of aspirin would be about 2,000 bottles of 100 tablets each — consumed at one time. Similarly, with 100 proof whiskey, the daily dose would be about 1,600 quarts.

Some recent research by the Addiction Research Foundation of Ontario (**The Journal**, March 1) provides a case in point in which both methodology and conclusions are suspect. This study purports to show that chronic marijuana intoxication in rats over a six-month period produces an "attrition of brain cells," or alternatively, "an acceleration of the natural aging process." While the researchers did acknowledge that rat research is not necessarily transferrable to humans, they did not acknowledge any methodological shortcomings or alternative conclusions.

This study represents the pattern of much research on marijuana. Unrealistic dosage levels are frequently used, often without informing the reader of that fact.

Phillip Baridon, PhD
Bethesda, Maryland

Liberalization

Sir:

Your story, "BC Goes Easier on Alcohol" (page 1, July), has some errors picked up in a quote from J. Peter Stein.

(a) The University of California is all over the place, but not in Palo Alto. I work in Berkeley.

(b) I am not a "Dr."

(c) It is not true that "Room's work indicates increased prices have little effect on the problem drinker". In a review of the literature, I pointed out that little was known about who drinks less when prices rise; but it certainly seems unlikely that the "problem drinker" is immune to the economic motivations that affect us all — and in fact there is some aggregate evidence from cirrhosis mortality and direct evidence from Finnish skid-row-studies that price

Backgrounder

By DAVID ZIMMERMAN

NEW YORK — Revelation of the Central Intelligence Agency's fascination with the dangerous psychedelic drug LSD, as a chemical warfare weapon, is proof again that many abused drugs have legitimate beginnings. Then they are co-opted by the drug subculture at a cost to society well beyond their legitimate value.

LSD was discovered by the Swiss pharmaceutical manufacturer, Sandoz. Earlier, heroin had been synthesized by drug companies as a cough remedy. Now, narcotics processors, encouraged by the American Medical Association and the US dept. of agriculture, hope to embark on a new drug venture, which, if illicitly co-opted, might dwarf the damage done by LSD and perhaps even by heroin.

The plan is to cultivate, in the west, several square miles of the great scarlet poppy, and process the plant tops to obtain a drug raw material called thebaine.

Thebaine, chemists say, can be readily converted into drugs potentially abusable and up to 6,000 times stronger than heroin. The yield in "highs" could be a staggering 120,000 times greater than from an equivalent field of opium poppies.

Ironically, the main justification for great scarlet poppy farming and thebaine extraction is to increase the availability of medically useful drugs like codeine, without dangerously increasing the world's acreage of opium poppies. Most legal opium is

Thebaine: a potential for mass abuse

turned into codeine. But codeine can also be made from thebaine. The great scarlet poppy is rich in thebaine, but yields little or no opium. Hence planners have assumed it is safer.

This assumption can be questioned, as can the assumption that Americans need more codeine, which is the justification for the great scarlet cultivation program.

Americans use enormous amounts of prescription and over-the-counter codeine products — about 100 million courses of treatment annually, according to industry figures. What is more, the opium processors' Washington lobbyist, Mrs Jane McGrew of the law firm Steptoe & Johnson, projects a doubling in domestic demand for codeine in the six years between 1972 and 1978.

This is projected wholly on the basis of sales. Mrs McGrew offers no statistics to suggest there has been or will be a doubling in the amount of mild to moderate pain suffered by Americans to justify a doubling in demand for a drug to suppress it. She and other industry people suggest the rising demand relates to the broadening of Americans' health care through Medicare, Medicaid and other health plans.

What seems at least as likely is that more and more patients whose pain might be relieved by aspirin, which is cheaper and does not entail a visit to the doctor and a prescription, are getting codeine, which they do not really need.

Aspirin and the aspirin-like acetametaphin are "wonderful drugs," says analgesic expert Dr William T Beaver of Georgetown University in Washington, DC.

"The problem is they are less costly, and people don't value them enough. If they cost more, and required a prescription, people would utilize them more, rather than codeine.

"There is no evidence," he adds, "that using 65 mg codeine is better than two aspirin or two tablets (600 mg) of acetametaphin."

Dr Beaver is a firm believer in codeine as a drug. "There's a legitimate demand for codeine," he says. "But it's not like penicillin. No one is dying for lack of codeine — or is going to."

It is fair to say that if the great scarlet poppy plan can be justified as a medical necessity, it will have and should have a high priority with government planners. But if, as the evidence suggests, it may serve corporate profits and doctors' preferences more than patients' needs, then the project needs to be scrutinized with the utmost caution.

There can be no way to tell whether, or if, thebaine from domestically-cultivated great scarlet poppies will be diverted into illicit drug channels. What seems clear, however, is that a potential for abuse exists. And there is no way to predict how or where it might occur.

Underground chemists, suppliers, and their clients what is more, tend to follow and co-opt the science and technology of legitimate drug makers. By creating a large-scale industry in great scarlet poppy culture and extraction, legitimate enterprise and government cannot help but entice individual workers inside, and underground operators outside, to divert and duplicate, and in every way possible, exploit a lucrative new manufacturing process.

The one certain way to discourage this would be for the federal government to decide not to permit industrial cultivation of great scarlet poppies for the extraction of thebaine.

THE JOURNAL welcomes letters to the editor for publication. Letters, which must be signed and kept as concise as possible, should be addressed to The Editor, The Journal, Addiction Research Foundation of Ontario, 33 Russell Street, Toronto M5S 2S1, Ontario.

changes do affect the "problem drinker's" behavior.

(d) "Room . . . concludes that easier access to alcohol does not have a significant relationship to an increase in alcoholism": This statement is also not true, although the opposite statement would not be entirely true, either. There is no simple relationship which can be summed up in a sentence. The relaxed attitudes that tend to go along with "easier access" may produce a lowering of social problems with drinking but an increase in health problems. Some restrictions appear to influence consumption and thus perhaps "alcoholism"; others in other situations appear not to.

I take it that the basic reasons for the BC changes were considerations of general public policy: to increase equality of access to alcohol, to enhance the convenience of the public, to reduce the extent of governmental control of private behavior, etc. These kind of political and ethical considerations have their own validity irrespective of the pragmatic effects of the legislation on "alcoholism".

While any prudent legislature should consider the practical effects of legislation, there is no reason to kid oneself that the pragmatic effects on alcoholism will always be what one would desire — or that such effects will be decisive on what legislation is passed.

Robin Room
Social Research Group
School of Public Health
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Berkeley, Cal.

(More — page 15)

Guest Book

THERAPEUTIC communities (TCs) for drug dependents are coming of age where legitimization is sought by its advocates.

These communities have proliferated like wild flowers throughout North America during the past 10 years and may represent a large and powerful constituency to be reckoned with by the mental health establishment.

At the recent National Drug Abuse Conference in New Orleans, I witnessed public and private negotiations, where talk of centralization, coordination and organization was heard from many corners.

Gaining momentum is the newly-formed North American Association of Therapeutic Communities and an elite offshoot, Therapeutic Communities of America, itself made up of the larger (over 100-bed capacity) and more powerful TC's.

A new international journal published in Canada, *The Addiction Therapist*, emphasizes the advancement of the therapeutic community, and an organizing committee is currently planning an international conference on therapeutic communities, to be held in Europe in the summer of 1976.

Once considered highly experimental, unorthodox and amateurish, the TC "movement", with its enthusiastic leaders, has grown tremendously in the past 10 years. It may have some very legitimate concerns to raise, such as parity of funding with other mental health institutions, licensure of paraprofessional personnel, community and academic recognition, etc.

Although the largest concentration is in the continental United States, TCs have spread to Puerto Rico, Hawaii, Canada, England, Malaysia, Sweden, France, Holland, Belgium, Thailand, Brazil and Venezuela.

The interesting quality inherent in the TC is its ability to be adaptable, flexible and viable without compromising its very essence.

Somewhat analogous is the symphony orchestra where many variations on a theme can be performed. The TC variations can be seen in alcoholism programs, schools, mental hospitals, private sanitariums, growth centres and quite recently in industry.

In almost every major drug treatment program in North America, including methadone maintenance clinics, one will find an ex-addict graduate of a therapeutic community on staff.

In Canada, where I am executive director of The Portage Program for Drug Dependencies Inc., a therapeutic community, some critical issues are surfacing:

1. Has the Federal Government appropriated enough money to support both alcoholism and drug treatment programming?
2. Is there a need for a TC in Canada's major cities?
3. Does the Non-Medical Use of Drugs Directorate, Canada's primary funding agency in this field, have sufficient documentation about the TC to insure its place within a national strategy?
4. Is government satisfied with the cost/benefit ratio of the TC?
5. Do we have enough *trained* addiction and alcoholism counsellors to meet the demand?
6. What is the Non-MUD role in training and staff development?

There are many more questions that must be addressed by the federal department of health and welfare as well as other governmental health agencies throughout the world, as the TC becomes a social institution that can no longer be ignored or treated as "token" in the overall scheme of things.

In the absence of answers, I submit that responsible government health agencies do not have a complete understanding of the TC nor have they valued its potential.

The policy of diverting funds to new and unproven projects every year does not allow sufficient time for the established programs to develop adequately, nor is there the time and resources to conduct a careful evaluation of the existing programs.

To this end, I have a number of recommendations for Canada:

- A therapeutic community be established in every major city where the incidence of drug and alcohol abuse warrants a residential treatment centre.
- The Portage Program with its demonstrated effectiveness in the treatment of drug and alcohol dependents be used as a national model to which addiction workers may go for internship and intensive training.
- Every methadone maintenance clinic be affiliated with a TC to insure that patients wishing to be abstinent after a period of chemotherapy get the opportunity.
- The Non-MUD, Innovative Programs Bureau, declare a moratorium on funding new projects until it is satisfied that existing proven programs can not provide the additionally needed services.
- The criminal justice system under Canada's solicitor-general take full advantage of the TC as an alternative to prison for the addict and alcohol criminal offender.

*** John Devlin is executive director of The Portage Program for Drug Dependencies Inc.**

By Wayne Howell

ACCORDING TO a report in The Journal, (August issue), the working groups and special symposia of the International Institute on the Prevention and Treatment of Alcoholism arrived at seven 'major conclusions' at the closing session of their recent conference in Helsinki.

The first major conclusion was that alcohol programs in industry may be the most important of all treatment efforts because in any given community the work force may represent a large percentage of the population.

Now there are those of a somewhat dogmatic bent who tend to disparage this "major conclusion" because they feel the Institute is hedging, afraid to come right out and say the work force 'does' represent a large percentage of the population.

Their deprecations aside, the Institute is to be congratulated for formulating the concept of work-force-as-possible-percentage-of-population and having the fortitude to present it to the world as a major conclusion.

The second major conclusion was that more accurate international statistics are needed. The Institute is to be congratulated for the forthright manner in which they have addressed this problem and have gone on record in favor of more statistics.

To fault them because they did not face up to the challenge of defining whether a bit more, a lot more, or an awful lot more are needed is to be picayune.

The third major conclusion reached was that the nature and goals of treatment cannot be divorced from their cultural settings.

Now this concept has been put forward before at various times, by various people, at various conferences.

But where the Helsinki conference broke new ground was in the decision to discard the 'should not be discarded....' concept absolutely in favor of the 'can not' concept and then link the two words into one (i.e. 'cannot'), the use of this emphatic contraction being an indication of this International Institution's willingness to break new ground and not to stand on precedent.

The fourth major conclusion — that more education about alcohol is needed in schools and medical centres — is a bit of a shocker.

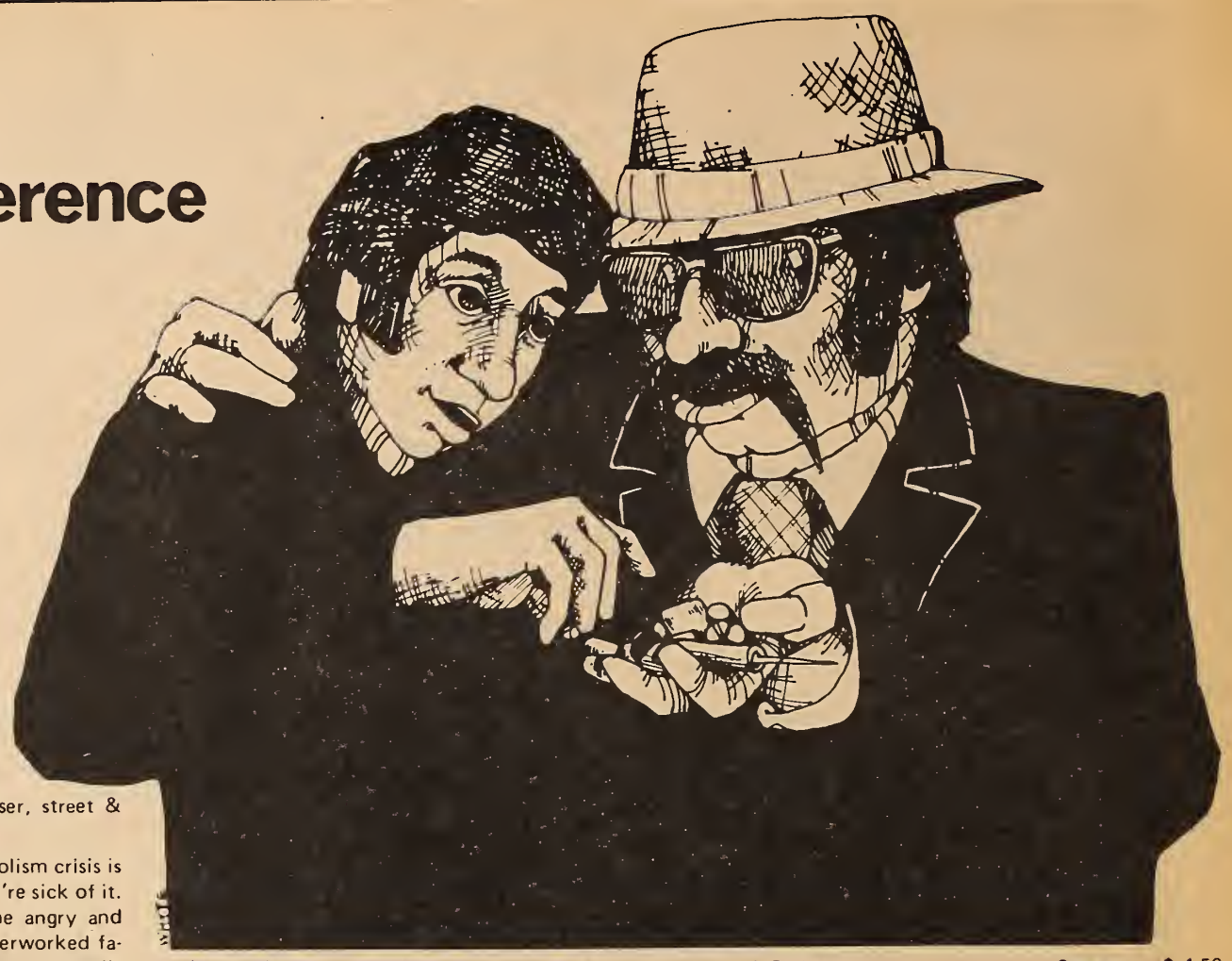
One can only speculate as to the deliberations that took place in the Helsinki bear pit — the heated discussions, the acrimonious debate, the frantic lobbying, and the final vote on the "major conclusion" with the delegates streaming into the conference chamber for the moment of truth — but it is apparent that somewhere along the line the decision was taken not to recommend more education in the home.

We do not have time here to discuss the remaining "major conclusions."

Nor do we have time to discuss the various "minor conclusions" of the Helsinki conference which were not reported in the press — such as the conclusion that the sun always rises in the east and why it looks like it rises in the south-east is because Helsinki is a long way north.

What's the difference between you and a pusher?

Maybe he communicates better.



You can bet the corner pusher communicates. And you can bet he knows just about every angle in the book. Unfortunately, the pusher's information and ease of communication sometimes rivals your own. You're the one with the uphill fight of communicating his opposite message. You're the one who must be more credible, more realistic, more in touch with the issues than any corner pusher. You've got to get wiser, street & otherwise.

We know and you know that the drug abuse and alcoholism crisis is a lot bigger than even the statistics dare speculate. You're sick of it. You see them every day — the burned-out people, the angry and confused families, the valiant overworked people in overworked facilities trying to deal effectively with a problem they are not really sure they understand. You hear the empty words every day. You see funding programs die every day. But you're still here and you're still fighting. God bless you — we'd like to help.

We are different. We are beautifully private, completely volunteer and gloriously independent. We've had valuable hard times and we've got guts. We've got the information and thinking you need to help keep on top of what is happening now and what is going to happen later. You've watched public sentiment swayed, legislation drafted and passed, laws enforced, funding begun and ended, entire treatment modalities phased in and out, sometimes at an almost whim-like speed.

We think we can help slow it down for you and throw in some perspective — join with us. We've got the superb monthly National Council on Drug Abuse Newsletter, which is accompanied with supplementary monographs, articles, and bulletins almost every month. We've got educational cassette tapes on treating the o.d. patient; learning about drug abuse and alcoholism. We've got 16mm color films on methadone maintenance and detoxification, books, reprints, studies, and abstracts on drug and alcohol abuse, as well as psychotherapeutic theory and technique.

Lest we forget, we also have the famous Methadone Maintenance Institute fighting T-shirt — advising everyone "Don't do dope, or other bad things". (This T-shirt has been known to stimulate conversation at every level and has also set many a pusher's heart atrembling in fear. You'll love it.)

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Buddhist monks concentrate on cure through the mind

Alcohol endangers life

Buddhists seek cure

By JEAN McCANN

BANGKOK — The Buddhist religion is being involved here as an antidote to increasing alcohol abuse, according to Prasap Ratankorn of the Ministry of Public Health.

Various sects of Buddhists have joined with the Hospital for Buddhist Priests in health education projects, including mass use of radio and television, he said.

Stress in these projects, however, is on the danger to life with alcohol, rather than on abstinence, one tenet of the Buddhist religion.

"Certain groups of Buddhist monks are working, with great determination and sacrifice, to cure alcohol and drug dependence," he said, with emphasis on applying the tenets of the religion to the mind.

"Enlightenment, the highest goal of Buddhist practice, is but freedom of the mind, freedom from defilements (Kilsea), and clinging (Tanha) and attachments (Upadana) of every respect . . . This being so, the methods and practices of the Buddhist monks are to concentrate on the cure through the patient's mind. To adapt this to modern terminology, one may say that the monks are aiming at the cure and rehabilitation through the means of altering the individual's psychic basis and behavioral disorder."

Dr. Ratankorn said that the Buddhist approach is a positive one, and that counsellors should not make their clients feel embarrassed or ashamed, as some did "who told poor alcoholics that alcohol makes up various kinds of bad blood that makes alcoholics ugly, eg:

"1) Snake blood — that is why drinkers sway in walking;

"2) Dog blood — that is why drinkers bark like dogs;

"3) Pig blood — that is why drinkers can eat their own dirty thing;

"4) Bird blood — that is why drinkers are so noisy, and have slurred speech;

"5) Tiger blood — that is why drinkers are so aggressive, and harmful to others.

"These sarcastic words," said Dr. Ratankorn, "give no help to the alcoholic, and will make matters worse. Since all of us here fully agree that those who suffer from alcoholism defeat themselves by their own minds because they have no self-control, I would like you to look for a new hope for these poor friends by encouraging them to follow the Buddhist way of life.

"I quote: 'If a man conquers a thousand times a thousand men, and another man conquers himself, the latter is the greatest of the conquerors'."

Around the world

RED MOONSHINE

The Soviet Union ranks first in the world in consumption of distilled spirits per person of drinking age (beyond 15 years) and moonshine contributes "25% to 30%" of the alcohol, says Professor Vladimir G. Treml, an economist at Duke University in the US. His report is published in the Journal of Studies on Alcohol, published by Rutgers University Centre of Alcohol Studies.

DRY DAYS

Wine-loving Hungarians have a two-day prohibition of alcoholic drinks safely behind them for another five years after their recent elections and the attendant temporary ban on drinking. The New York Times says the ban had more impact on most people than the election itself which resulted in no measurable change for the nation of its Communist leadership.

RED WHITE AND SMOKY

Hot from the tobacco fields of America, the processing factories of Russia, and a Swiss packaging plant is the Apollo-Soyuz cigarette, courtesy of the American side of Philip Morris. A "scientific and technical cooperation agreement" paved the way for the cigarette. Some 90% of the 500 million planned packs are slated for Soviet sale, 7% for European, and 3% for Americans. Release was scheduled to coincide with the safe return of the space ships on the joint Soviet-American Space Mission.

AUSSIE LEISURE

The recreational priority of 25% of 12-to 14-year-old Australians is to get drunk "sometimes" or "often". A further 10% "wish they could" get drunk. About half of those between ages 15 and 20 years say getting drunk is "a way of passing time". The figures are from a government report based on interviews with more than 1,200 young people between 12 and 20 years of age.

"LADIES" SAY NAY

Women of Madras state, India, managed to get prohibition reinstated there according to Prabhudas Balubhai Patwari, senior advocate of the Supreme Court of India. He said in a speech women voters were in a big majority in an election in Dindigul and drove out the government nominee and Indira Gandhi's candidate. "The ladies expressed their resentment against the evils of drink." he said.

German teens embrace alcohol

By JOHN DORNBERG

WIESBADEN—Virtually all juveniles between the ages of 12 and 18 years have at least experimented with alcohol.

That is the conclusion of a study conducted, and just released here, by the Hessian state ministry of social welfare.

The survey was conducted among teenagers in one representative large city, one small town, and one rural district in this West German state.

The motivations for teenage drinking, according to the study, are "curiosity", "boredom", "to demonstrate maturity, especially to peers", "to overcome inhibitions and insecurity", and "to deal with stress and conflict situations in the home, school and social circles".

Although beer is the most widely consumed alcoholic beverage among teenagers questioned in the survey, champagne, wine, vodka, whisky and schnaps are also factors.

The investigators who conducted the study established five distinct groups of juvenile drinkers.

One group, by far the largest, encompasses those youths who drink once or twice a year, usually in the company of and with permission of their parents, for festive family occasions. Wine, champagne and beer are the beverages usually consumed by them at such times.

A second group consists of those who with varying frequency consume alcoholic beverages at parties and on festive occasions, usually in the company of their age-peers.

The third group embraces those who drink moderate amounts of alcohol, but regularly, usually after peer-group activities such as athletic tournaments, soccer matches or club meetings.

A fourth group consists of those youngsters who drink to solve problems at home or school.

The fifth major group is made up of those who meet regularly with age-peers "primarily to get drunk".

Heroin mixtures a new concern

By DAVID EHRLICH

GENEVA — Heroin-caffeine-strychnine mixtures are bedeviling European narcotics control experts.

A sharp increase in fatalities was reported at the recent United Nations Commission meeting by French and German authorities, who blamed such mixtures.

Many national and international agencies have publicly blamed Amsterdam for its permissive *ambiance* and claim that it has become a major transit point for illicit traffic in many substances.

Wilhelmina Gasthuis of the pharmacy department of the University Hospital has been analyzing heroin samples for treatment centres there.

She noticed a "dramatic change" about a year ago. Samples submitted by the police contained either caffeine or caffeine and strychnine in grey or pink-brown granules packed in heat-sealed plastic bags. The usual specimens had been the familiar white powder.

Quantitative analysis revealed heroin contents ranging from 10% to 60% averaging 40%; caffeine content from 35% to 63%, averaging 50%; and strychnine from 0.5% to 4.8%, averaging 2%.

During 1974, Gasthuis says, police seizures of heroin packaged for the street market contained these additives in almost 60% of the samples and caffeine alone in about 40% of them.

"Where and why?" she asks in a report prepared for the UN division here. "We thought these mixtures were prepared in the country of origin and . . . that the heroin was not diluted for profit but . . . for some use other than by injection . . . the usual method (here)."

She wrote to 14 forensic laboratories in eight countries, requesting information. There were four replies.

Seldon Bacon honored

Seldon Bacon (left) was honored recently at a recognition dinner marking his retirement as director of Rutger's University. A special presentation was made by Dr. Morris Chafetz who steps down this month as director of the National Institute on Alcohol and Alcoholism.

UK concern over barbiturates

By ALAN MASSAM

LEEDS, ENGLAND — By a narrow majority the annual representative meeting of the British Medical Association here has rejected a call for voluntary restrictions on the prescribing of barbiturates.

Opponents of the move spoke of maintaining clinical freedom, but there is a strong possibility the government will impose some kind of limitation.

This was explained after the debate by Dr John Bennett, a hospital consultant physician in Kingston-upon-Hull and chairman of the newly formed and government-financed ginger group CURB (Campaign on the Use and Restriction of Barbiturates.)

Dr Bennett reported growing concern about the use of barbiturates other than for the treatment of epilepsy and induction of anaesthesia.

The excessive use of barbiturates for "other purposes" was giving rise to anxiety about not only the medical but also the social implications.

Dr Bennett said CURB was "most determined" to draw attention to the misuse of barbiturates by young people who were seeking sensation and experimenting with drugs.

"Those who have studied the matter are in no doubt about the reality and seriousness of the problem, but the facts that relate to it are difficult to establish," he said. "The young people concerned or 'in the know' are reluctant to discuss the matter and, in any case, unreliable witnesses.

"Furthermore, there is a marked tendency for the geographical centres of misuse to shift, both within large urban centres and from one part of the country to another. For instance severe misuse, including perhaps intravenous injection of barbiturates will flare up in one area, die down, and appear again elsewhere.

"The difficulties of obtaining hard evidence are compounded by the fact that misuse is subject to fashion. It seems that over the past few years, young people have increasingly tended to experiment with a number of drugs in combination or with drink.

It is very difficult to know therefore, when considering antisocial behaviour by young people and the accidents including road accidents in which they become involved, what part barbiturates have played.

"The police, social workers, educationists and many voluntary and local drug liaison committees, believe it has been significant and regard the situation with great concern."

Dr Bennett said most misused barbiturates originated from doctors' prescriptions — there were vast quantities left over in bathroom cabinets — and there was an undoubted implication that some doctors were virtually prescribing barbiturates on demand.

Alcoholism and nutrition in the Arctic

By HELEN LILLIE

WASHINGTON DC — Some striking hypotheses on the relationship between adequate nutrition (with sufficient protein) and alcoholism, were presented at the 50th Anniversary meeting here of the Society of Woman Geographers.

Valene L. Smith, PhD, professor of anthropology at California State University, Chico, Cal., and an expert on the Arctic, termed it "this planet's last Frontier".

It has been opened up within the past 25 years by the airplane, she told the 450 members of the society. And, during this period, the whole way of life of the Eskimos has changed drastically. So has their rate of alcoholism, currently their "Number One health problem", she said.

"Eskimos drink liquor faster than any group I have ever seen — as much as one-fifth of 110-proof vodka in an hour. Then they stagger away from a party — often to freeze to death enroute home," she said.

She said she had seen employed Eskimos drink themselves into joblessness and school teachers send home children as young as eight years old to recover from hangovers.

Social scientists, said Dr Smith, attribute much of this alcoholism to the frustrations of accumulative stress, particularly inability to adjust to the change from a stable existence, underwritten by hunting, to an immersion into the 20th Century with its enticing and expensive gadgetry and an economy built around such things as tourism.

Dr Smith believes, however, that "frustration is an effect rather than the primary cause" of alcoholism among the Eskimos. Many families still continue to hunt and fish, she said, and these people live largely on the high protein-fat diet which aboriginally provided 97% of their food intake.

The highest incidence of alcoholism is among those families who are so poor they subsist on the cheapest available food — "white bread, pancake flour and cornstarch puddings liberally sweetened with quantities of jam and syrup".

Dr Smith believes their rapid and substantial dietary shift from a high protein diet to one in which carbohydrates predominate, is the cause of pronounced malnutrition.

Manitoba pushes low-alcohol beverages

By MANFRED JAGER

WINNIPEG — The Manitoba government will put up to $150,000 into advertising and promotion of a new series of low-alcohol beverages during the next few months, with the first of the drinks — four new beers — on sale since late July.

The four brands of beer are marketed under the names of Gentle Ben (Uncle Ben's), Cascade Pilsner (Carling O'Keefe), Cool Spring (Labatt's) and Crown Lager (Molson's). And while beer in Manitoba has traditionally packed punches of up to 5.5% volume alcohol, the new brands are limited to only 3.9% volume.

The low-alcohol beverage move by manufacturers, greatly encouraged if not initiated by the provincial government, will be followed up soon by the introduction of the first of a series of liquors with low alcohol content — a gin containing only 35% volume alcohol.

It is to be joined later by rye, rum and vodka brands carrying the low alcohol content.

The government's promotion budget will pay for the advertising of the latter products as well, J. Frank Syms, chairman of the Manitoba Liquor Control Commission, has indicated. Manufacturers names will be rotated in advertisements so that it will not appear the government is favoring any one.

Dr John Banmen, assistant deputy minister in the government's department of corrective and rehabilitative services, said in an interview the move toward lower-alcohol beverages is not so much aimed at reducing out-and-out alcoholism as at making it easier for the social drinker to enjoy his favorite drink without endangering himself or others to the extent traditionally observed.

There is little hope in government circles that problem drinkers or pathological alcoholics — Manitoba has 30,000 of the former, including about 16,000 of the latter — will make widespread use of the new low-alcohol beverages.

As for pricing, it now costs Manitobans five cents more for a glass or a bottle of their favorite regular beer — unless they'd rather switch to one of the low-content brands.

The switch to what the liquor commission calls "low ball" beer means a saving of five cents to the tippler. The low-content brew will cost 65 cents a dozen less than regular beer.

Although the low-alcohol beverages are not expected rapidly to reduce the number of alcoholics in the province, a senior official in the department of corrective and rehabilitative services said the new drinks and their promotion by the government very directly address themselves to the alcohol abuse problem in the community.

"It is now recognized that alcohol has become the number one drug problem," said the official. He said by introducing low-alcohol beverages it is hoped the number of alcoholics will grow less rapidly.

Low-alcohol spirits, once they have entered the market this fall, will sell for 45 cents less than regular-strength brands, the government official said.

The official said promotion of the new brands will be by posters in government liquor stores and in all newsmedia.

"We will encourage the low alcohol liquors to be sold in licensed premises," said one government spokesman. "Because they're cheaper, we feel that the licensees are going to push them to make more money.

"They will be allowed to charge the same for a low-alcohol drink as they charge for a regular brand drink."

The spokesman said this month is the government's target date for having the low-alcohol spirits in every beverage room in the province.

New Books

By RON HALL

Adolescent Drug Use: The Problem In Perspective

. . . by James A. King, William A. Muraco, and Karl Vezner
The Bridge
(Suite 561, 1 Stranahan Square, Toledo, Ohio 43604), 1974.
178p.: $3.25

Using a computer mapping technique, the diffusion of drug usage in a region is visually and statistically analyzed in this report of a survey of drug usage in Lucas County. Research design, sampling technique and sample characteristics are presented.

Clinical Pharmacology Of Psychoactive Drugs

. . . edited by E. M. Sellers
Addiction Research Foundation, (33 Russell Street, Toronto, Ontario. M5S 2S1), 1975
index: 239p.
(hard cover $13.50; paperback $10.00)

As part of the International Symposia on Alcohol and Drug Problems held in 1973, the papers presented in this volume range from the epidemiological aspects of suicidal drug intoxication to the molecular basis of psychoactive drug action. Important developments and methodological problems are discussed.

All In The Family: Understanding How We Teach And Influence Children About Alcohol

Operation Threshold, U.S. Jaycees, (Box 7, Tulsa, OK 74102), 1975
bibliography: 48p. $1.00

This booklet has been designed to be read alone, to be used by parent with child, or as a participant's workbook. Responsible use and non-use of alcohol is given emphasis with respect to how children are taught or infleunced.

Anomalies In Drug Abuse Treatment

. . . by Assemblyman Emeel S. Betros (chairman)
Temporary State Commission to Evaluate the Drugs Laws
(270 Broadway, Room 1800, New York, NY 10007), 1975

In this State of New York Legislative Document No. 11, over thirty recommendations for improving the delivery and funding of drug and alcohol treatment services are outlined. Included is an overview of approaches to solving the problem of driving while impaired.

Alcohol Education Materials: An Annotated Bibliography

. . . by Gail Gleason Milgram
Rutgers Center of Alcohol Studies (New Burnswick, NJ 08903), 1975.
bibliography: index: 291p.: $12.50

This bibliography of alcohol education materials published between 1953 and 1973 contains critical annotations for each of the 873 books, pamphlets, and periodicals which are cited. Standard bibliographic information is presented and the price of each is included if available.

Other Books Recieved

Drugs on the Market: Cady, John F. D.C. Heath and Company, Lexington, 1975, 153p., $13.

The Family vs Drink and Drugs: Levy, Michael H., and Green, Helen I. Institute for the Study of Drug Misuse, New York, 1974, 70p.

Alcohol and Other Drug Use and Abuse in the State of Michigan: Final Report: Macro Systems, Inc. Office of Substance Abuse Services, Michigan Department of Public Health, Lansing, 1975, 206p.

DWI Law Enforcement Training Project: Student Manual: Carnahan, James E., Holmes, Donald M., Keyes, James A., Stemler, Jerry D., and Dreveskracht, Charles L. U.S. Government Printing Office, Washington, 1974, 364p., $3.80.

Biomedical Research in Narcotic Abuse Problems: Non-Medical Use of Drugs Directorate, Ottawa, 1975, 334p.

Clinical Pharmacology of Psychoactive Drugs: Sellers, E. M. (ed). Addiction Research Foundation, Toronto, 1975, 229p.

A Manual on Drug Dependence: Kramer, J. F., and Cramer, D.C. World Health Organization, Geneva, 1975, 107p.

Selected Bibliography on Detection of Dependence-Producing Drugs in Body Fluids: Chrusciel, T. L., and Chrusciel, M. World Health Organization, Geneva, 1975, 67p.

Alcohol programs miss the target

MILWAUKEE—Most alcohol education programs miss the main target — the alcoholic — because they do not stress the physiological and psychological facts of addiction, contends Dr James Royce of Seattle University.

This is especially true in programs that advocate "responsible drinking," he added. "Such a campaign implies two basic fallacies: that everyone should drink and, more important, that every one can drink in moderation."

Dr Royce, professor of psychology and head of the alcohol studies program, said: "Every alcoholic starts with controlled drinking, believes he drinks responsibly, and wants very much to do precisely what he cannot — to drink like everybody else does."

The facts of addiction, tissue tolerance, and withdrawal are just as real as the facts of compulsion and learning, he said at the annual forum of the National Council on Alcoholism here. These must be included in all education programs to make them effective.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

The National Alcoholism Training Program for Professionals will hold eight seminars from September 1975 to May 1976, St Louis Missouri. Information: Dr. D. J. Pittman, Social Science Institute, Box 1202, Washington University, St. Louis, Missouri 63130.

Fifth International Conference of the International Association for Accident and Traffic Medicine and the International Council on Alcohol and Addictions — Sept. 1-5, London, England, Information: Archer Tongue, Executive Director, ICAA, Case Postale 140 1001 Lausanne Switzerland.

1975 Annual Meeting of the Alcohol and Drug Problems Association of North America — Sept. 14-18, Palmer House, Chicago. Information: Alcohol and Drug Problems Association of North America, 1130 Seventeenth St., N. W., Washington, D.C. 20036.

Canadian Foundation on Alcohol and Drug Dependencies — Sept. 14-19, Quebec City. Information: OPTAT, 969 Route de l'Eglise,Quebec 10e, P.Q. G1V 3V4.

District Nine Scientific Program (Sports Medicine) — Sept. 27, North Bay, Ont. Day in Therapeutics presented by Ontario Medical Foundation in cooperation with North Bay District Medical Society. Information : W. Murray Mitchell, M. D. , 181 McIntyre St., W., North Bay Ont.

Ontario Consultation on Women, Alcohol and Drugs — (closed meeting) Sept. 29-Oct. 1, Ottawa, Ont. Information: Ms. L. Pinder, ARF Regional Office, Suite 202, Pebb Bldg., 2197 Riverside Dr., Ottawa, Ont. K1H 7X3

Interdisciplinary Conference on Conjoint Emergency Care — hosted by the Emergency Nurses Association of Ontario — Oct. 1-3, Toronto, Ont. Information: Ms. M. Victoria Eld, Apt. 5, 62 Old Mill Road, Etobicoke, Ont. M8X 1G7.

Symposium on Headache — Oct. 4, Toronto, Ont. Information: The Director, Office of Postgraduate Medical Education, University of Toronto, Toronto, Ont. M5S 1A8.

49th Annual Convention of the American School Health Association — Oct. 8-12, Denver, Colorado. Information: American School Health Association, ASHA National Office, Kent, Ohio 44240.

International Symposium on Alcoholism — Oct. 11-13, Porec, Yugoslavia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

First National Conference on Deliquency Prevention — Oct. 14-17, Niagara Falls, N.Y. Information: Mrs. Virtuoso, National Conference on Delinquency Prevention, Niagara Falls Convention Bureau, P.O. Box 786, Falls Street Station, Niagara Falls. N.Y. 14303.

Third Annual Conference of the California Association of Alcoholic Recovery Homes — Oct. 31 - Nov. 2, Asilomar, Calif. Information: Joe Collins, Executive Director, CAARH, P.O. Box 5396, Santa Monica, Ca. 90405.

Fourth Information and Feedback Conference — Nov. 12-13, Toronto, Ont. Information: IF Conference Committee, Counselling and Development Centre, York University, Toronto, Ont.

First National Conference on Occupational Alcoholism and Drug Abuse — Nov. 17-20, Ottawa, Ont. Jointly sponsored by Humber College and Addiction Research Foundation. Information: Jim Simon, ARF, West Toronto Branch, 4143 Dundas St. W., Toronto, Ont. M8X 1X2.

International Symposium on Alcohol and Drug Dependence — Nov. 29-Dec. 5, Bahrain, Arabian Gulf. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Second Caribbean Conference on Strategies of Drug Abuse in Developing Countries — Feb. 1976, San Juan, Puerto Rico. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Conference on Alcoholism and Drug Dependence — April 4-9, 1976, Liverpool, England. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Sixth International Institute on the Prevention and Treatment of Drug Dependence — June-July 1976, Hamburg, Germany. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

From Down Under

Sir:

I am dropping this short note to congratulate you and your Editorial Board on the excellent material in **The Journal**.

I have been reading the publication for quite some time now and, from a law enforcement point of view, I find it very informative, instructional and educational. It is one of the best medical journals I have had the pleasure of reading.

Once again, keep up the good work.

Best wishes.

Det/Sgt 1/c K. S. Astill,
Officer in Charge, Drug Squad,
Criminal Investigation Branch,
Surry Hills, N.S.W. 2010,
AUSTRALIA.

Ganja in Jamaica: a provocative report

By Milan Korcok

ONCE CONSIDERED barren, the state of cannabis research is now in full bloom.

As national commissions in both Canada and the United States have noted, more reports have been written about this enigmatic weed during the past 10 years than in any other previous period.

The results of these investigations have often been contradictory, and have fed into the bitter quasi-political disputes raging between the hawks and the doves.

But few have added substantively to the most elusive, most critical set of questions: What happens to those who smoke marijuana long and consistently in their own complex human environment?

Research on human subjects has been limited. Scientists have concentrated on short-term, acute reactions as monitored among captive populations puffing away in artificial, laboratory surroundings.

Consequently, the release of *Ganja in Jamaica*, a report compiled by an impressive consortium of scientists from the United States, the West Indies, and Canada, couldn't come at a better time in that it adds a mass of provocative and enlightening information in an area previously starved for fact.

Ganja in Jamaica shows that despite, long, persistent and, by North American standards, heavy use of marijuana, the working class Jamaican suffers precious few medical ill effects that can be attributed to use of his "herb".

If he does suffer some damage to his health — some incidence of hypoxia did show up — it remains a toss-up as to whether that damage is a function specifically of the weed, or of the act of smoking itself. In Jamaica, ganja is combined with regular tobacco.

The report emphasizes that the psychiatric findings do not bear out any of the extreme allegations about the deleterious effects of chronic use of cannabis on sanity, cerebral atrophy, brain damage, or personality deterioration. There is no evidence of withdrawal symptoms, and none of overdose reactions or of physical dependence.

Perhaps most provocative was the finding that not only does marijuana NOT induce an "amotivational" syndrome, and not only does it NOT produce an apathetic, indolent class of people — but it is used deliberately, and with apparent success, to spark motivation, to fuel a work ethic, to encourage the hard, tedious, physical labor which is the working class Jamaican's only recourse in scratching a living out of an uncooperative terrain.

Ganja in Jamaica, a medical anthropological study of chronic marijuana use, presents the findings of an investigation carried out by the Research Institute for the Study of Man (New York City) in collaboration with the University of the West Indies. The study was sponsored by the Center for Studies of Narcotic and Drug Abuse of the National Institute of Mental Health.

The principal co-investigators were Vera Rubin, director of RISM, and associate director Lambros Comitas.

Ever since the project report was first presented to NIMH in early 1972, there has been a growing discussion, in scientific circles, about its findings. As many saw it, the publication would go a long way to filling those conspicuous information voids that had plagued researchers and policy makers for a long time.

There was much anticipation about what effect this report would have on the existing cannabis dialogue.

As sociologist Dr Erich Goode, in his own review of *Ganja in Jamaica* claimed: "Pathology is news, normality is not."

Dr Goode himself appears frustrated by the imbalance of the media in stressing pathology and neglecting normality. He cites several references (Stenchever's chromosome studies, Nahas' investigations of cellular immunity, and Campbell's cerebral atrophy work) and wonders at the overall social effect of their headline treatment. Yet when careful refutations of such research are published, says Dr Goode, they go quietly by the board, relatively unnoticed.

In 1974, for example, Dr Gabriel Nahas and colleagues at Columbia University published a report in Science, claiming that long term use of marijuana may impair immune response capabilities. The headline press was immediate.

Yet, when in 1975 Dr Steven C. White and colleagues from the Veteran's Administration Hospital in Washington published an article in the same journal, refuting many of Dr Nahas' claims, they couldn't make the news.

"The medical and psychiatric findings of *Ganja in Jamaica* do not deserve the same fate," says Dr Goode. "The five chapters on the acute and chronic effects of Ganja are one of the most significant sets of findings on cannabis ever assembled in a single study."

Dr Goode singles out these portions because he is less than enthusiastic about the anthropological, the historical and sociological sections of the book which he faults for methodology and lack of depth.

Nonetheless, these sections make fascinating reading in that they add a wealth of information about the individual's motivation for use, his perception of the drug, and its use as an adaptive mechanism that helps him cope with the limited resources of a harsh environment.

The study was a collective effort involving anthropologists, pathologists, psychiatrists, psychologists, and various groups of physicians at the University Hospital in Kingston. It has drawn much strength, both from a research as well as a narrative point of view, from the fact that so much work was conducted in the field.

Field studies involved several segments. First there was a pilot study in mid-1970 in which anthropologists surveyed six localities, five rural and one urban. This was followed in 1971 with anthropologists and sociologists fanning out into seven communities representing the various social and geographic crosscuts of Jamaican, working-class society.

Clinical studies, done on 60 working class males (30 ganja smokers and 30 non-smokers) were done in the faculty of medicine at the university. The subjects were selected from four of the seven surveyed communities.

All were admitted to the university hospital for six days of intensive physical and laboratory investigation. In addition, the subjects were assessed psychiatrically, and they underwent a battery of psychological and neuropsychological testing.

Ganja use among Jamaican working class people is pervasive. The "herb" is smoked, brewed in tea, mixed in tonics (with rum and/or wine). It is given to children by the teaspoon or the teacup to "make their brains good" and to make them "strong and smart."

It is taken in the form of tonic (mixed with rum and set to age for 15 days) mixed with icewater for treatment of "bellyache" or drowsiness.

One 17-year old lad claimed the virtue of one cup of ganja tea every day "to make you powerful in sex and cricket".

Ganja is also used in poultices and compresses for relief of pain, and as a dressing for open wounds. Older women recommend that infants be washed with ganja leaves at birth.

One Rastafarian (ganja use is an article of the sect's religious practice) mixes ganja with his pepperpot soup, and others cook ganja with their greens and bananas.

In one of the sampled communities (believed typical of class Jamaica) ganja was used in one form or another in nearly 70% of the homes. Almost all drank ganja tea, and more than 50% of the homes had one or more ganja smokers.

Most users smoke in their homes and yards, in the working fields or in the bush — where they can have "safe and loving thoughts" safe from the police. And when they smoke, they SMOKE — prodigious quantities compared to North Americans.

In one of the surveyed groups, the average user consumes seven "spliffs" a day. A spliff is about a four-inch long, hand-rolled cigarette. Heavy use is defined as more than eight spliffs, moderate use five to eight, and light use one to four.

Since the typical Jamaican smoke has at least three times the THC potency of the marijuana used in the United States, it seems the heaviest using Jamaican takes in between 10 and 25 times as much as what is considered the "heavy using" North American counterpart.

What is so intriguing about this heavy usage is that it is so integral to the Jamaican work ethic.

When, under the eye of videotape units, the subjects were tested in the field going about their farming chores, they appeared to feel stronger, work harder and faster, and expend more effort at their jobs while under the infleunce of ganja.

At one session, a group of a dozen workers first shared some ganja provided by the host farmer, then for 15 minutes "worked like demons" talking and laughing as they moved up the hill, forks piercing the earth in a close, straight line. Once their pace slackened and fatigue set in, the farmer called for more "herbs".

THE BACK PAGE

The physical status of the 60 subjects was assessed by detailed medical history and examination, heart and lung radiography, electro-cardiography, respiratory function, blood chemistry, liver and renal function, hematological, serological and chromosomal studies. In addition, blood and urine samples were sent to the United States for analysis for peripheral thyroid hormone levels and steroid excretion.

Among the ganja smokers thus assessed, the duration of ganja smoking ranged from seven to 37 years, with a mean of 17.5 years. The number of spliffs used per day ran from one to 24, with an average of seven.

No significant physical abnormalities were found that could be related to ganja use. The only real difference between the groups was that smokers were an average of seven pounds lighter, suggesting the possibility that habitual smoking causes some suppression of appetite.

Minor ECG abnormalities, attributable to an obliterative disease of the small coronary vessels, were found in about 30% of both ganja users and controls, but the researchers linked this to the heavy smoking activity (tobacco included). There were indications of functional hypoxia among heavy, long-term smokers, but it was impossible to distinguish between the effects of ganja and the tobacco use itself.

No significant differences were found in cortisol secretion, or in peripheral thyroid hormone levels between the smokers and controls, and reports of chromosome studies of 18 smokers and 15 controls revealed no significant difference between the groups.

The incidence of mild chromatid breakage (2.3% among smokers and 2.9% among controls) was no higher than that found randomly in other studies at UWI.

Similarly, the hematological examinations and liver function studies showed up no significant differences between the users and the controls.

Psychiatric assessments and electroencephalographic studies were unable to spot any differentiation between the smokers and controls in respect to mental illness, alcoholism, or abnormalities of mood, thought processes, or behavior.

No differences could be found in the number of arrests, or convictions for crimes, and no observed relationship between ganja use and economic status.

Quite clearly, says the report, there was simply no evidence that cannabis use leads to loss of competitive striving or to any "amotivational" syndrome.

The psychological assessment developed by the researchers was also strongly supportive of earlier findings reported in an independent study by Canada's Dr. Marilyn Bowman, now of Queen's University.

Dr. Bowman's data indicated that long term cannabis use did not produce any demonstrable intellectual or ability deficits "nor any evidence to suggest schizophrenia or permanent brain damage."

"In fact, the slow degenerative brain processes initiated by other drugs such as alcohol and cocaine, do not appear to create any comparable changes in chronic marijuana users," says Bowman.

"And the disruptions of memory associated with heavy chronic alcohol use and with acute marijuana intoxication, are shown not to lead to any significant chronic memory disruptions in heavy regular users of marijuana."

Whatever the extent of credence ultimately given to the Jamaican studies by a pathologically-oriented public, they will have provided an invaluable resources in respect to measuring certain of the effects of chronic use.

They will have shown that the expectations people have of a drug, and the social conditioning of the user, are critical to the result achieved by its use.

Alcoholic workers turn to other drugs

By BETTY LOU LEE

HAMILTON, Ont. — Older alcoholic workers are increasingly turning to marijuana, barbiturates and other drugs while on the job, says Lloyd Fell, director of Lifeline Foundation of Toronto.

The drugs are promoted to them by younger workers who deal in them.

"We're finding a greater number of older fellows who've been on booze for years going over to other drugs," Mr Fell told the 16th annual Institute on Addiction Studies at McMaster University.

"The younger guys who sell them tell them they're asking for trouble drinking on the job — 'I can smell you a mile away' — but the use of other drugs can go undetected."

He estimated that six percent of the 74 persons in his Steelworkers rehabilitation program are now in this category, compared to five percent last year. They range from 40 to 55 years old.

"They go back to the booze at home at night, and we're finding that some of them are getting cross-addicted . . . they become a nervous wreck . . . . This is going to be an increasing problem to cope with, this cross-addiction of 45 to 55-year-olds."

Mr Fell said three drug rings had been broken up in Toronto steel plants with the help of police, "but there's always someone to take the place of the sellers — kids pushing to support their own habits."

Most workers aren't familiar enough with the odor of marijuana to realize it's being smoked by colleagues near them, he added.

Terry Meagher, secretary-treasurer of the Ontario Federation of Labor, said later the problem of multiple drug use among older alcoholic workers is probably a general and growing one, not peculiar to the steel industry.

The OFL has been trying to encourage the 50 local labor councils in Toronto to promote joint union-management rehabilitation programs for addiction, but so far only a small fraction of the 750,000 workers represented by the federation are covered.

There is sometimes a problem with unions accepting a role in such programs "because they are usually cast in the role of protecting the worker against management."

Lloyd Fell

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CFADD-time to do or die

By GERRY HILL

QUEBEC CITY — The Canadian Foundation on Alcohol and Drug Dependencies has just completed its most successful conference ever, lost its chief executive officer, and is facing critical financial problems.

Its rank and file membership is growing steadily, its remaining employees are enthusiastically committed, and its board members are convinced the foundation is on the move as a national force in Canada.

At the same time, however, its operating budgets are being slashed dramatically, total staff complement at its national office is being reduced to four from six, and the existing lease on its Ottawa premises may be re-negotiated.

But, the situation is not as contradictory as it sounds, "although things may appear that way on the surface," according to Dennis Taylor, who resigned suddenly as executive vice-president of the CFADD on the opening day here of its 10th annual conference.

Foundation staff, conference participants and board members at the four-day meeting in Quebec City seemed to agree.

Most ascribed the confusing mix of good news and bad news on the CFADD's state of health to fairly predictable, though publicly dramatic, organizational growing pains.

"When a national, independent organization is trying to get off the ground, there's bound to be a good deal of tension and disagreement aroused while it's establishing directions," said Mr. Taylor.

"In fact, the first staff person hired by a board of directors to break the ice often has to consciously stir up emotions and create a little controversy simply to get people involved and interested in the organization's future.

"For example, in talking publicly about the foundation's becoming a serious national organization, I clearly had to ask some pointed questions about the federal government's Non-Medical Use of Drugs Directorate," he said.

In the June edition of the CFADD newsletter, Taylor said there was a great deal of confusion about the objectives and role of that federal agency and that nearly half of the CFADD agency members "felt NMUD had little or no understanding or awareness of what was happening".

In earlier interviews, (**The Journal**, March 1975) Mr Taylor had pressed publicly for the development of CFADD as a populist movement involving, as individuals, the general public and workers in the alcohol and drug field.

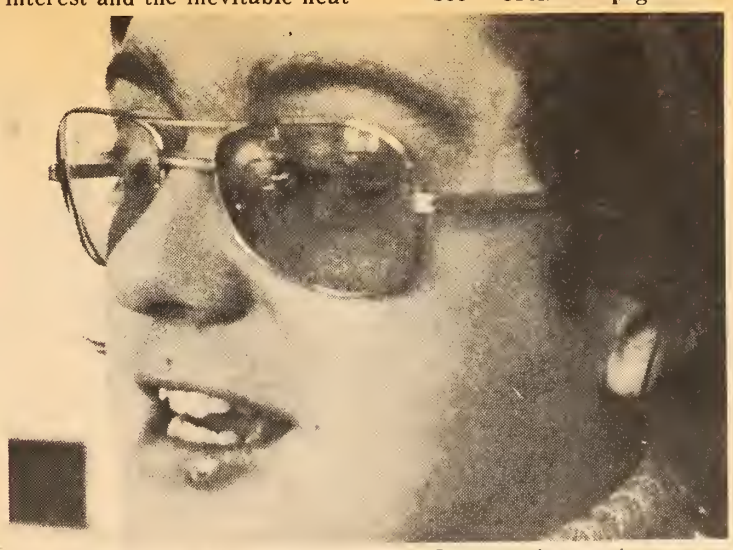
This was in marked contrast to the foundation's former role as the ultra-low-key voice of the official provincial agencies across the country.

"Getting someone in at the start to make waves is a very necessary part of getting an organization on the move.

"But, once you've aroused some interest and the inevitable heat that comes with it, it's sometimes better for the organization concerned to move the individual who stirred things up out of the way, taking a lot of the flak with him, while somebody else takes over," said Mr Taylor.

Despite rumors that Mr Taylor's criticisms of the Canadian alcohol and drug establishment prompted his demise as executive officer, the more immediate issue underlying his resignation was money, or

See — CFADD — page 2



Dennis Taylor resigns CFADD executive post

Take control over destiny workers urged

By MILAN KORCOK

CHICAGO — Alcohol and drug treatment workers in the United States, increasingly dependent upon federal funding, have been urged to recapture some control over the course of their own destiny.

Karst Besteman, deputy director of the National Institute on Drug Abuse, called for participants at the annual meeting of the Alcohol and Drug Programs Association (ADPA) to reassert themselves, to make their presence felt, and to become more involved in the policy decisions that lead to government appropriations and spending in this field.

Too much of the burden for such decisions is left to the executive branch and Congress, said Besteman, and too little responsibility is assumed by the drug and alcohol constituency itself.

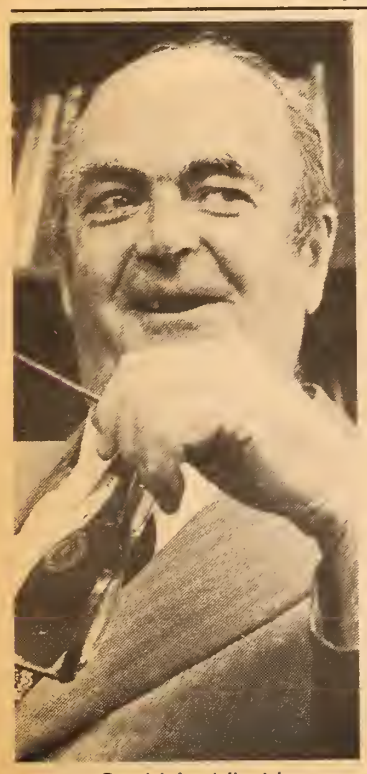
"Having the internal workings of the federal budget process serve as the overriding factor in the future of government support in drug treatment is just too much of a closed loop for the good of the field.

"Elbow your way in," Besteman exhorted the ADPA. Besteman emphasized there are still too few individuals, within both the executive and Congress, who believe that drug treatment is a legitimate function in the social health area.

Because of this deficiency, the administrators of federal drug funding as well as program people in the field, are often faced with unrealistic and impractical demands to prove the worth of their actions, he said.

Besteman's challenge to the ADPA was reinforced by Willard O. Foster Jr., special assistant to NIAAA, who urged getting more of

See — Control — page 5



David Archibald

Contrary to lawmakers' view

Public favors alcohol controls

By GARY SEIDLER

HAMILTON, Ont. — The executive director of the Addiction Research Foundation of Ontario has called for a moratorium on any further liberalization of alcohol control measures.

In an address to the annual Institute of Addiction Studies here, H. David Archibald said further relaxation of laws governing alcohol should cease "until we know more clearly what these measures are likely to entail in terms of public health".

Mr Archibald wondered whether Ontario's policy-makers would have been as enthusiastic to lower the legal drinking age (from 21 to 18 years) had this public health criterion been applied.

The ARF chief suggested lawmakers may be wrong in assuming the general public wants increased liberalization of drinking laws.

Referring to a recent series of studies by the ARF, he said the majority of people appear to favor tighter restrictions on drinking.

(The ARF polled 1,000 Ontario residents for its Social Policy and Alcohol Use survey. Results will be published shortly).

Mr Archibald said social policy-makers are constantly being exhorted by the media to adopt more "civilized" laws with respect to where and under what conditions people be allowed to drink.

"But, in fact, when we analyze these attitudes, we find a somewhat different interpretation.

"The research shows that a majority of respondents favor a restriction on sales to alcoholics, that they reject increasing the number of taverns and licensed restaurants, that most want no increase in the number of liquor outlets or in their hours of sale, and that a majority reject expanding the number of self-service liquor stores."

Even more encouraging, Mr Archibald noted, was the survey's result that the respondents accepted the validity of such controls on

See — Alcohol — page 2

Marriage: Synanon Style pg. 16

...INSIDE

Scientists, clinicians assailed

Establishment has "failed wretchedly"

By GARY SEIDLER

QUEBEC CITY — "Addictionists" will have to become more serious in their work if the real and persistent problems associated with increasing use of all intoxicants is to be held in check.

In a provocative address at the opening of the annual Canadian Foundation on Alcohol and Drug Dependencies conference here, Toronto psychiatrist Dr Andrew Malcolm held hope for the future.

But, he warned, drug use will never diminish while leaders in the field continue to believe that drug dependence is "victimless", that it is not a problem of public hygiene, and that the ideal society is one in which all men must be free to achieve the altered state of consciousness through intoxication at will.

Dr Malcolm lashed out at the scientific and clinical establishment — well represented in the audience — for "failing wretchedly" to curb the explosion of drug use during the 1960s.

He called many of them "pusillanimous" and "gullible" and lacking in common sense.

Remembering the trends of the Sixties, the controversial Dr Malcolm said:

"We regarded the explosion of drug taking with dismay at first but before long we resorted to a most ingenious series of rationalizations to justify our inaction.

"And it was during this period that we lost track of our need to be serious."

The drug craze, he recalled, was accompanied by persuasive literature that talked incessantly about the new culture, about enlightenment, about the "third consciousness".

Children were described as radiant and profound and everyone over 30 years of age was regarded as incapable of comprehension.

"Under the circumstances, it seemed altogether more comfortable for the people most learned in this field to capitulate; and this is precisely what most of them did," Dr Malcolm charged.

The speaker used the occasion to continue his three-year feud with the Addiction Research Foundation of Ontario.

The ARF, he said, became "desperately hip" during the Sixties.

"This potentially important organization swept away many of its most serious and learned employees and hired in their places people whom it felt would contribute to an appearance of relevance and social responsiveness." (Dr Malcolm was fired by the ARF in 1972).

The ARF, Dr Malcolm continued, became heavily involved in "human potentialism" which had a "most parlous effect" on the legitimate work of the organization in the fields of research, treatment and education.

The work of Canada's LeDain Commission also came under the Dr Malcolm gun.

" . . . The result was not any moderating influence on the rising curve of consumption, it was, rather, just the opposite.

"The process of marijuana acculturation was greatly advanced by the work of this group of progressive people."

Dr Malcolm reserved his most vicious attack for "the philosophers of drug dependence" who offered the concept of "wise personal choice".

According to this concept, said Dr Malcolm, no expert should ever presume to express a point of view. He should, instead, restrict any statement to a simple recitation of the facts, their costs and benefits.

While appearing to be a civilized approach, Dr Malcolm condemned the concept as "the most unsavory rationalization to be advanced in our field for decades.

"It had the immediate effect of allowing everyone to retreat from making any sort of value judgement based on personal experience and learning.

"It assumed that everyone in the population was equally responsive to education; and in the early 1970s to hold that this was simply not true was to be identified immediately as an agent of Big Brother."

Dr Malcolm claimed the "wise personal choice" philosophy did incalculable damage because there remained four crucially important groups of people only rarely affected by any presentation of facts only. He identified these as the mentally ill, the unintelligent, the very young and those criminally inclined.

"In short, the vision of these experts was limited by their intense desire to believe fervently in the goodness of man and in the perfectability of his society."

Gazing in the crystal ball

QUEBEC CITY — In the near future, the "mischievous suggestion" that alcoholics might return to social drinking will be rejected, predicts Toronto psychiatrist Andrew Malcolm.

"We do not have the ability to solve the problem of compulsiveness in any significant number of people, and until we do, the exciting concept of social drinking as a goal will have to regarded as premature," Dr Malcolm told the Canadian Foundation on Alcohol and Drug Dependencies.

"To think otherwise is to be fundamentally unserious and lacking in common sense and humility."

In his defence of Alcoholics Anonymous, the keynote speaker expressed the hope that as fellow workers in the field of drug dependence, "we will cease our occasional belittling of AA".

He labelled as "foolish and dangerous" those suggestions that AA incorporate the techniques of sensitivity training into its program.

In keeping with the conference theme — Anticipation — Dr Malcolm also gazed into his crystal ball to predict a variety of future trends.

In the course of the 1970s, he predicted much ground would be regained as "addictionists" become more serious about the persisting problems of drug dependence.

While he supported Bill S-19 — to remove jail sentences for first time offenders of simple possession of marijuana — Dr Malcolm said we will soon drop the term "soft" when speaking of that drug.

"To speak in a cavalier way about the sweetness and benignity of marijuana will be held to be both ignorant and unserious."

He predicted a declining rate of increase in use of marijuana, LSD and other hallucinogenic drugs.

Andrew Malcolm

Solvent sniffing, he added, would also decline in absolute terms.

While alcohol — having defeated all its challengers — will be clearly recognized as the recreational drug par excellence in the years to come, Dr Malcolm predicted important changes in attitudes toward alcohol consumption.

"We will cease our foolish desire to be just as civilized as the French" (per capita alcoholism rates in France are the highest in the world).

Dr Malcolm also predicted society would become much tougher with the drinking driver.

In addition to allowing use of the breathalyzer at the scene of an accident, Dr Malcolm would like to see suspects submit to saliva, urine and even blood tests within minutes of an accident.

"The problem, you must all realize, is that in the future it will be astounding mixtures of chemicals that will diminish the capacity of people to operate machinery safely; and most of these drugs will not be detectable in the breath."

Dr Malcolm said the time is long overdue for action to decrease the consumption of prescribed tranquillizers and stimulants, some of which, he said, are "tremendously psychoative and vicious".

CFADD faces critical financial dilemma

(continued from page 1)

more precisely, a crucial lack of it.

Richard Anthony, a lawyer in Victoria, BC, was elected president of the foundation at the Quebec conference and is openly concerned about its financial health.

"Dennis Taylor asked the CFADD board for a mandate to continue with the same approach he had been using to date — lots of innovation, lots of idealism and lots of hope," said Mr Anthony, a former chairman of the Alberta Alcohol and Drug Commission.

"However, a careful look at the balance sheet and the spending implications for the future showed that innovation can be very expensive, particularly when the organization is no way near the financial self-sufficiency we need in order to avoid collapse when our existing grants run out," he said.

CFADD is just a little more than halfway through a three-year funding arrangement with the Non-Medical Use of Drugs Directorate worth approximately $125,000 each year.

The original understanding was that the federal funds, from the agency which Dennis Taylor has been recently criticizing, would be used as "seed money" while a national secretariat was established and a variety of permanent funding sources were found.

Prior to 1974, the foundation had existed exclusively on paper and did little more than provide the flag under which an annual conference staff from provincial agencies was held, with the relevant groups holding the event in rotation.

However, with the aid of the three year NMUD grant, the "new CFADD" was to become a catalyst bringing together diverse groups, individuals and ideas and gaining wide public attention and support for positive national but non-governmental action.

Since the new look was introduced at the 1974 Edmonton conference, progress has been made on some of the loftier goals. But the crucial question of long range financial stamina remains unsolved.

For example, the CFADD's consultation on drug and alcohol abuse among women held in Levis, Quebec in August was considered a great success and issues raised there seemed to dominate this main event in Quebec City.

There are also now more than 50 agency members of the foundation across Canada where there were none before. Each agency pays a $50 annual membership fee while the 136 individual members contribute $20 each.

While these figures clearly boost morale and enthusiasm, however, the total contribution of $5,250 appears painfully small in comparison to the present annual budget of almost $150,000.

"We're obviously going to have to concentrate on major belt-tightening over the next few months while trying to devise a means of surviving long enough to put the foundation on a realistic financial base," said Richard Anthony.

While board members wrestle with financial dilemmas and the search for a new executive officer, the CFADD office in Ottawa will be directed by Francoise Berthiaume, the information director in charge of public relations with the foundation thus far.

Alcohol control

(continued from page 1)

the basis of public health grounds.

"The survey was even able to conclude that if the control of beverage prices could be seen by the public as a health-related measure, many of those who want government to maintain or reduce current prices might be persuaded to change their views."

Mr Archibald pointed out that any government program must concentrate on suppressing supply as well as demand, or an unbalanced policy results.

While making it clear he did not advocate a return to prohibition, Mr Archibald suggested "we may have been unwise in letting that experience propel us so far in the other direction.

"Let's not be so vehement in rejecting the possibility that certain types of controls, developed in concert with a public recognition of the need for some controls, might in fact prove very effective."

He outlined several control options available.

They included the control of the number and types of outlets as well as the days and hours of sale; control of the age at which alcohol is bought and consumed; regulation of the means by which alcoholic beverages are advertised and marketed; manipulation of the levels of taxation which reflects the overall cost of alcohol in the marketplace.

Given that 80% of Ontario adults now drink — between 10 and 15% excessively — an increase in overall consumption will result in two inevitable consequences, according to Mr Archibald:

— People who do not now drink, must start drinking; people who now drink must drink more.

"In either case, greater numbers of people become vulnerable to destructive drinking styles.

"Unless we are prepared to tolerate a broad assault on our health status through this kind of accelerated drinking, I believe we have no option but to dig in our heels," he said.

Womens' issues boosted

By GERRY HILL

QUEBEC CITY — Concerted program action on issues surrounding alcohol and drug abuse among women was confirmed as a high priority by the board of the Canadian Foundation on Alcohol and Drug Dependencies at its annual meeting in Quebec City.

A list of 13 recommendations was presented to the board by a program committee representing participants at the consultation on Alcohol and drug abuse among women, staged by the foundation in Levis, Quebec in August.

Among the recommendations accepted unanimously were those calling for active lobbying by the CFADD within the medical profession regarding treatment for women alcohol and drug abusers, and tighter control over prescribing habits with women patients.

Policy statements from the consultation on women also called for mandatory refresher courses and in-service training for treatment personnel dealing with female alcohol and drug users.

A central drug registry system for prescription drugs, research on government treatment of special female populations (unmarried pregnant women, teenaged addicts and members of ethnic minorities), and a national survey of treatment facilities available for dependent women, were among the other needs identified by the group.

Major Austin Millar, vice-president of the foundation said the board had accepted the 13 recommendations in full and was committed to doing "as much as is possible to stimulate action on these objectives, within the bounds of our mandate and fiscal resources".

Margaret Jones, chairman of the womens program committee described the response of the board as "the best we could have expected given the pragmatic problems inherent in achieving many of the things we want".

"Of course, we realize that CFADD cannot do everything on its own but we're pleased that the board showed such a positive response to our presentation. I know we'll get some action," she said.

In general, womens' issues proved to be most popular at the conference with the seminar "Women and Drugs" outdrawing its opposition by a wide margin of participants.

More reports by ANNE MACLENNAN from a Consultation on Alcohol and Drug Abuse Among Women held in Lévis, Quebec and sponsored by the Canadian Foundation on Alcohol and Drug Dependencies

Reaching women and knowing how to treat them

'It's an enormous problem'

Edith Gomberg

THE "WHOLE LOT of disagreement" over whether the emancipation of women is going to lessen or magnify the extent of alcoholism among women, will probably never be resolved, Dr Edith Gomberg said here.

Dr Gomberg is professor of social work at University of Michigan, Ann Arbor.

The question is "a very emotional issue that ties together women's rights, changes in patterns of acceptable social behavior, and dissatisfactions and frustrations of contemporary existence — for males, for God's sake, as well as for females.

"I think it would be foolish to accept a simple formula. To say that if you free women from their traditional roles you will not have alcoholism, is as simplistic a trap as the antithesis of the argument that emancipating women leads them into evil ways.

"The traditional role (of women) is undergoing change before our very eyes. But, to deny the discontent of women in the suburbs and the drinking in the cocktail lounges and country clubs is foolish.

"To find jobs for all these women outside the home does not carry any magic solution either. You substitute one set of pressures and strains for another.

"And a vulnerable lady can become an alcoholic working in the home or working outside the home," said Dr Gomberg.

She said the question often arises whether women should be advised to get themselves employed outside the home if marriage and homemaking is frustrating and unsatisfying.

"I am inclined to be a little suspicious of simple answers. In the first place, the vulnerable woman who has begun problem drinking is a person whose conflicts about her femininity are very deep and are not easily resolved by the simple act of taking a job.

"And if working outside the home gave protection against alcoholism, we should have less alcoholism among working women than among housewives."

While data is not complete, "we do know that industrial programs for troubled employees show a high rate of drinking problems among women workers," she said.

As for the "fight about whether the rates are going up, whether there are more women alcoholics per population unit than there were a decade ago", Dr Gomberg said: "I think it's a silly fight because who cares?

"The fact is even if the number remains stable, we still have an enormous problem reaching these women, getting them to come into treatment, knowing what to do when they do come in."

Domineering, sneaky -- unfair labels

A GROSS injustice has been done to the wives of alcoholics by labelling them Domineering Dorothys and Castrating Catherines.

This is the opinion of Dr Edith Gomberg, professor of social work, University of Michigan, Ann Arbor, and keynote speaker at the consultation.

"It is the female as evil-doer: 'Men are alcoholics because their wives have a stake in keeping them alcoholics.'

"There's no blooming evidence to support this. It has a fantastic impact on the wife and her behavior. If she seems to be uptight and neurotic, it's understandable. What about research on the husbands? Until recently, it was zero."

She referred to a study suggesting that the majority of husbands of alcoholic women were psychiatrically disturbed.

"What the hell are we talking about? Are they depressed because their wives are alcoholics or did it pre-date their wives' alcholism?"

In some way, wives may make adjustments. There are pay-offs. One has to study family dynamics. What happens after he or she gets sober is a very important question, she said.

Part of the image that everybody has of women is also that they are sneaky and sly. "It's such a silly issue. In the first place, by social definition there are more women alcoholics who are not publicly on view because more women stay at home. They drink where they work and they happen to work at home.

"So, it's less a matter of trying to conceal it, than a matter of being socially assigned to a place where drinking isn't publicly visible.

"Also, if you have a differential attitude in society as to whether it is worse for women to be intoxicated, (and you do) then you have to be pretty damned dumb if you're a female alcoholic to go out and make yourself as visible as possible. So there are a whole lot of social and cultural reasons as to why they are less visible. That's the way it is."

They should recognize their limitations

Behind their masks, MDs are confused

BEHIND THE see-all, help-all image that still clings to them, doctors are anxious and confused about addictions, says a Montreal family physician.

Michelle Cousineau

Doctors have "a kind of sorcerer's image", Dr Michelle Cousineau said here.

But it is "just a carapace. When their clientele tell them what to do, they listen," she said.

Dr Cousineau is director of a nutrition clinic in Montreal and a medical consultant to Quebec's ministry of social affairs.

"We are guilty of giving pills by the ton. We are guilty of sometimes pushing women into the drinking or drug habit."

This happens, she said, because doctors are too busy to do more than give pills and because they do not recognize addiction or potential addiction because, more often than not, they were not taught in medical school and have not learned in practice.

It also happens because doctors often believe addicted patients are troublesome patients, she said.

Women themselves must also share some of the blame for what is happening to them, said Dr Cousineau.

"Women especially are asking for magic tricks to cure their symptoms — sometimes because they do not want to go further than that. They are afraid.

"They are asking because they are not well-informed about the real role of the GP. They think he is a wizard who plays a magic role."

A woman should ask not for pills but for what is the real cause of her dizziness, her anxiousness, she said.

"If we could teach the clientele, the women, what to ask for, that would help change the attitudes of the doctor."

Meanwhile, she said, doctors should recognize that sending patients away with pills is not going to make them less busy.

"People come back with their problems. Pills don't settle anything. We have to teach doctors to go to the source of the disease ... to diagnose and pick up the addicts before they are chronic

In this, she said, agencies in the addictions field have an important role to play. They should use their authority to impress upon medical schools and professional medical associations, the "urgent need" for more awareness and understanding among doctors of women's problems with addictions.

Doctors should also recognize their own limitations, said Dr Cousineau.

The GP's role is "to receive the woman and make a good examination. With someone who is intoxicated, the reaction often is not to give a good examination. I don't know exactly why. Maybe we are bored. They are like children because they cannot give the right answers.

"But, we can do an examination, even if someone is intoxicated, and we must.

"After that, we have to take care of the pathology we discover and only that, if we can cure the cause, not just give pills to cover the symptoms."

Perhaps most important is for doctors to be informed of resources. If they cannot give the kind of attention that may be needed, and some might not be able to, then they must know where to refer their patients.

"I don't mean just send a patient to someone else. We have to 'phone and check afterwards and find out what kind of care the patient received. If it is not suitable, doctors should refer her to somewhere else," she said.

"We have to know our own limits ... what we can do and cannot do. Our main task is to be informed of the resources and there are a lot of resources if we would just stop and learn them and refer correctly.

"If we could only make the GPs do only their own job and know their limits and refer at the right time, it would be marvellous and I don't think we could ask any more of them than that. But it's a big job."

Alcohol's impact on families

'Whole rotten hornet's nest'

THE IMPACT of alcoholism on the family is a "whole rotten hornet's nest to stir around in", according to Dr Edith Gomberg who has devoted much of her career to studying alcoholism among women.

It could be, as some say, that a mother's alcoholism disturbs a family more than a father's does. "It could be. But saying that just doesn't make it so.

"You're going to have to convince me by going out and doing the studies that mothers with drinking problems create more disturbance in their family," said Dr Gomberg, professor of social work, University of Michigan, Ann Arbor.

She termed family therapy the "greatest invention that anybody has come up with" as far as female alcholics are concerned.

Any service that deals with alcoholic women and does not also involve their children in the program is "doing a very dumb thing", she said here.

"I really believe ... and I have no data, just instinct ... that the sharing of responsiblity for the situation is even more critical to women than it is to men.

"The only thing that I can think of by way of primary prevention is to take a group that is very vulnerable, a very high risk population like the children of alcholics, and for God's sake move in during childhood and early adolescence and try to see if you can deal with some of the problems.

"I feel very strongly that family therapy and services for children are very critical," she said.

Illicit drugs, drug deaths on increase in Manitoba

By MANFRED JAGER

WINNIPEG — Drug experts in the Winnipeg police department say deaths related to the abuse or misuse of drugs in this city are increasing.

And if recent large drug seizures are an indication, there are more illicit drugs than ever in the city, according to Staff Sergeant Jim Druchet, head of the RCMP's local 22-man drug section.

Heroin has been scarce in Winnipeg since the fall of 1973, when a well-known trafficker was jailed, police say.

There also seems to be less LSD around as users have become wary of the drug, Staff Inspector Ken Johnston of the Winnipeg police morality section says.

But S. Sgt. Druchet says more cocaine, liquid hashish and amphetamines have been encountered.

Morphine use has also been increasing in the city this year and it is believed the drug is taking the place of heroin to some extent.

Insp. Johnston feels the scarcity of heroin has contributed to an apparent increase in drug-related deaths, although at first glance this would seem a paradox.

"When there is no heroin around, (they) inject anything into their veins, coming up with all kinds of concoctions," he said.

These concoctions have often been more dangerous than heroin, with which drug users were at least familiar, and fatalities have resulted.

Dr. John Matas, St. Boniface Hospital methadone clinic director, and Insp. Johnston agreed that many drug users shun methadone because of the clinical aspect, because "it's not their thing".

"They prefer the cops and robber game", which is part of the illicit drug use, to the "tame game" of visiting the clinic daily for a dose of methadone, giving urine samples to show they are using heroin. and receiving counselling, Dr. Matas said.

Insp. Johnston said he thinks the public is less concerned about drug abuse than in the past. "I think it's become old hat to them. It's not news anymore."

NMUD sponsors $180,000 study of drug patterns

By BETTY LOU LEE

HAMILTON, Ont. — A comprehensive study of drug misuse patterns will be undertaken in the Hamilton area with a $180,000 grant from the federal Non-Medical Use of Drugs Directorate.

The study will include prescription, over-the-counter and street drugs as well as alcohol and tobacco.

It is the first study of its kind in Canada, and it could be repeated in other communities if methods of collecting such data prove feasible.

The grant is being used to set up an epidemiological field unit at McMaster University Medical Centre, and has been awarded to Prof Michael Gent, chairman of the department of clinical epidemiology and biostatistics.

Prof Gent said the first phase of the project will be to establish contacts with agencies and other data sources in the community, including hospitals, physicians, pharmacies, schools, and the police.

"We don't really have an idea of what's going on in the field of inappropriate use," said Prof Gent. "If we can set up a system for reliable data, we can define the problems and establish priorities for research and development. It's really a prototype to find out what's achievable in a monitoring system."

If the first phase goes well, the second phase will move to etiology and interventions.

The area to be included in the study is the Hamilton Health Region that stretches from the Niagara Peninsula to Tobermorey.

Dr Lowell Gerson, a medical sociologist, is research director for the field unit, and Dr Walter Spitzer is the principal investigator.

For purposes of the project, the unit will use the LeDain Commission definition of non-medical use — "use which is not indicated or justified for generally accepted medical reasons, whether under medical supervision or not." A drug is considered to be any substance that by its chemical nature alters structure or function.

Prof Gent said the unit might investigate such issues as the identification of drug-related physical, mental and social problems, the varying risks associated with increasing levels of drug use, identification of persons and groups at various risk levels, the personal, substance and environmental factors that contribute to various levels of use, the relative success of intervention strategies, and the changes in the extent and distribution of problems over time.

As examples of the type of studies that might be undertaken after data is collected, he suggested evaluation of programs to quit smoking, clinical and social histories of rehabilitated alcoholics, iatrogenic drug abuse, the role of the public health nurse in identifying persons with drug-related problems, marketing and distribution of non-medically used drugs in the community, and the role of family doctors in identifying and controlling drug abuse problems.

A short ride . . .

From executive suite to bottle

By MARGY HAGER

SAN FRANCISCO, Cal. — Picture the executive who has worked his way through the corporate structure from impersonal cubicle to plush executive suite, from modest, nearby home to suburban mini-estate with two to three hours of commuting.

As he reaches his fifth decade, this executive is either going to make his way to the top or fail to reach that pinnacle.

That fifth decade is going to be critical because of the tensions, anxieties, pressures that have been steadily taking their toll for 10 or 15 years, sapping his physical strength and affecting the quality of his work.

If that executive has borne his problems in silence — which he undoubtedly has, since executives are reluctant to share their problems feeling that others can handle the same problems and that to acknowledge them would somehow diminish his chances for advancement — he is going to suffer deep depression and he will be totally immobilized.

He may even consider suicide — many do.

Chances are all of his problems are significantly complicated by one other problem, which makes the ultimate solution much more difficult. The problem is alcoholism.

The problems of the executive in today's society were outlined in detail here at the annual meeting of the American College of Physicians by Dr. Charles P. Neumann, Medical Director Emeritus of the Silver Hill Foundation in New Canaan, Conn.

Dr. Neumann pictured the executive "compromised by stresses," who uses "alcohol as a cloak of many hues to hide from himself and from others the problems he feels are increasingly hard to face."

He is pressured to conceal his problems because the executive must never know he is not on a par with his peers, let alone that he is not up to the next problem.

Alcoholism, he observed, is a crutch, it "blurs reality" and "softens the pain."

But alcoholism also impairs production and when this is identified, the alcoholism is often blamed and not recognized "as a symptom of an underlying problem which needs to be, and which can be, treated successfully." This failure can doom any treatment to failure, he added.

Although all will reassure that they will stop drinking, only a few can because most are emotionally and physically exhausted and have "no reserve on which to call for the final and supreme effort," Dr. Neumann continued.

What these executives need, he emphasized, is to be removed from their work situation and their home, to be given rehabilitation and rest and individualized psychotherpay to help them recognize the emotional problems they have refused to face for so long.

Executive dilemma — (scene from ARF film, A Firm Hand)

Such people need to be shown solutions and guided to make necessary changes so that they can return to a world of realities, he continued.

The process usually takes two to three months and must be voluntary, he said.

The problem, as he outlined it, is not an indictment of the corporate structure, with its dehumanizing failure to recognize the value of an individual, but is a fault of a society which "emphasizes material values as a criteria to success," he said.

Turning the problem into the solution

By DAVID R. MILNE

SAN FRANCISCO — A good case can be made for the United States growing its own "dope crop", says John Maher, president and founder of a rehabilitation group called the Delancey Street Foundation.

The anti-drug establishment has a vested interest in narcotics traffic, that for every $1,000 profit taken by a drug dealer some grant-seeker will get $1-million, he told a meeting of businessmen at the Commonwealth Club here recently.

Instead of sending aging drug addicts around the schools — to show kids what drugs look like so they can identify the drug of their choice — the government should keep the half billion dollars it is funnelling overseas to fight traffic and recycle it through the US economy by getting into the drugs business itself.

Maher said one share-cropper with a tractor could outproduce an army of Turkish farmers and thus the US could co-opt and control the heroin business.

He conceded that some drugs would find their way to the street, but so would the money, thus removing many causes of addiction.

A product of a New York City ghetto, Maher left school in the eighth grade to become a full-time drug pusher.

He spent five years at Leavenworth and more time on drugs before he was drug-free, eventually forming his own rehabilitation organization.

According to Maher, methadone programs are run by "swine" who each day administer methadone to armies of addicts lined up outside their clinics.

Such power could play havoc with electoral politics.

In his talk about drug addicts and convicts and the kind of economic and social system that produces them, he urged that the prison system be dismantled so the government would be forced to find an alternative solution.

LeDain named federal judge

OTTAWA — Gerald LeDain, chairman of Canada's Commission of Inquiry into the Non-Medical Use of Drugs between 1969 and 1973, has been named a judge of the Federal Court of Appeal.

The announcement was made recently by Justice Minister Otto Lang.

Mr. LeDain, 50, a professor at Osgoode Hall Law School, Toronto, completed his work on the drug commission in December, 1973, when the commission's third and final report was tabled in the House of Commons.

Among the LeDain Commission's many recommendations — most of which have not been acted upon — was a bill to remove jail sentences for simple possession of marijuana. The bill was debated in the Senate recently and approved with some suggested revisions. It is scheduled to be dealt with in the House of Commons later this year.

Mr. LeDain's appointment to the federal court, which deals with all cases involving the federal government or government tribunals, will enable him to draw on his extensive knowledge of constitutional law and his experience as an advisor to the Quebec government.

Gerald LeDain

Impaired drivers underestimated

By MANFRED JAGER

WINNIPEG — A University of Manitoba team of accident cause and prevention researchers has come to the conclusion that alcohol abuse remains a major cause of road tragedies in Canada.

Because alcohol intoxication is often suspected but cannot be proved by law enforcement agencies, the incidence of alcohol-related traffic accident causation may be even greater than it appears, the team indicated.

The medical and engineering team, known as the Manitoba Committee for Accident Research and Safety, made its statement in a report on 31 traffic mishaps which occurred in the Winnipeg area during 1974 and earlier this year.

The latest progress report of the group, headed by Winnipeg trauma surgeon and surgery professor, Dr William Mulligan, says in 13 accident cases there was a definite relationship between the mishap and prior consumption of liquor by one or more of the persons involved in the accident. In another four cases at least there was suspicion of liquor abuse just before the accidents occurred. The use of illicit drugs may have been a factor in one additional case.

"The great tragedy of the alcohol-related road accident is that the young driver population is increasingly involved and the event itself tends to occur at high speeds where the potential for high-energy input to the body, and resulting injury are great," says the report.

The research team, which also includes bio-mechanical engineers, a human factors specialist, statisticians and engineers, as well as experts from other disciplines who are called upon when needed, says in certain persons the legal limit of 0.08% blood alcohol is too high.

"Blood levels of 0.05% probably evoke risk-taking behavior in the novice user.

"In many instances the effect of alcohol is compounded by other physiological or psychological aberrations," says the report.

"Currently before the emergency medical services committee of the Canadian Medical Association is a resolution to declare persons unfit to drive even with a trace of alcohol in the blood."

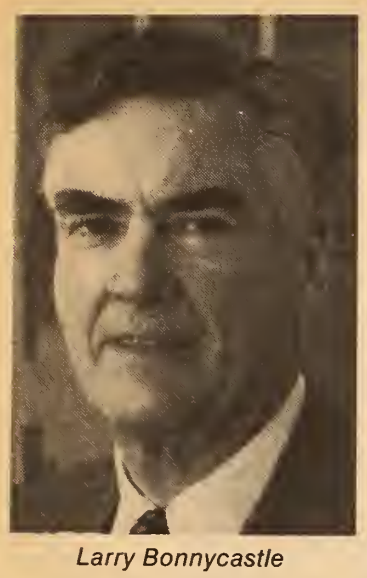
The survey report says no effective measures to prevent the intoxicated from driving seem to be in sight at present.

"There is great need for the public to recognize the hazard presented by the impaired driver and support measures to counter the threat," the report states.

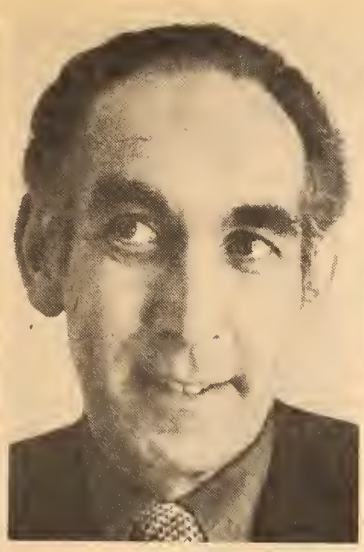
"The contribution of alcohol to accident causation is undoubtedly great, but under existing laws difficult to define precisely.

"Unless death or serious injury results, the driver is seldom requested to submit to a breathalyzer test or a measurement of the amount of alcohol in the blood or urine.

"Spurious reasons, such as a mild head injury, are used and acknowledged by courts as a legitimate cause for driver refusal to submit to breathalyzer analysis."



Larry Bonnycastle



Horace Krever

Lloyd Mussells

Krever Report

ARF-government study begins

By GARY SEIDLER

TORONTO — A joint Ontario government-Addiction Research Foundation committee has been appointed to consider at least two of the major recommendations contained in what has become known as the "Krever Report".

After sustaining a series of public attacks from a dissident group led by fired former employee, psychiatrist Dr Andrew Malcolm, the Addiction Research Foundation in April, 1973, appointed Dr Horace Krever, A University of Toronto law professor, to review the ARF's organization and work.

Dr Krever presented his often-critical report in February 1975 (**The Journal**, March 1).

To review the Krever Report's six major recommendations, ARF established a series of task forces. Within a few weeks, the agency acted upon one of these by retaining the services of a management consultant, Dr Lloyd Mussells, to review the organization's structure and to advise on changes in management methods and procedures that might be desirable.

In a September 11 memorandum to ARF staff, board chairman Larry C. Bonnycastle announced the joint committee was "actively at work". Mr Bonnycastle is committee chairman.

The joint-committee is considering Dr Krever's recommendation that a thorough study be done of the ARF's responsibilities and the extent to which they belong to the foundation or to other agencies of government in the health and community development fields.

In this connection, Mr Bonnycastle reported, Ontario Health Minister Frank Miller had asked that a committee composed of foundation and government representatives be established to review the role of the ARF in serving the broad needs of the province with respect to alcohol and drug abuse. The committee will be expected to comment on the foundation's activities and how they relate to the priorities and objectives of the Ontario Ministry of Health and other Ministries, in the field of alcohol and drug dependence.

The joint committee will also review the role composition and membership of the foundation's board of directors, an area which produced comment by Dr Krever.

In his report to staff, Mr Bonnycastle summarized the conclusions of the various task forces which studied individual recommendations.

With respect to Dr Krever's recommendation that legislation be enacted to permit ARF staff collective bargaining rights, Mr Bonnycastle stated that any initiative towards unionization should lie with employees — that each staff member is free to join a union, or not to join — that no person representing either the union or the foundation is permitted to interfere with the employee in making the choice.

Recognizing, however, that Dr Krever's recommendation related to his assessment that the level of employee morale within the foundation is "deplorably low", the foundation's task force studying the question outlined a number of specific recommendations designed to improve communications within the organization and improve working relations.

Another ARF task force decided against implementing Dr Krever's recommendation that research and clinical training now conducted in the foundation's Clinical Institute (an 80-bed hospital in Toronto) be transferred to the organization's research division.

The task force recommended that research and clinical training continue as the fundamental priorities of the Clinical Institute which, as a teaching hospital of the University of Toronto, is in a position to accept students and graduates for training in the field of drug addiction.

Dr Krever's "most important" recommendation called for the retention of outside consultants to study the foundation's management methods, structure, organization and personnel.

In this connection, the ARF called upon Dr Lloyd Mussells, a management consultant with Woods, Gordon and Co. Dr Mussells, a physician and administrator with extensive management background in the health care and research field, has completed his management review and is expected to deliver his concluding report shortly.

Control over destiny

(continued from page 1)

the decision process back to the state levels.

"Our future depends on the strength of our constituency."

As to what this constituency might expect from Washington by way of NIAAA funding, Foster painted a rather bleak picture.

He said the 1975 levels of appropriations and fund use was just over $146 million. The expectation was that in 1976, NIAAA might receive $154 million. This would be almost $3 million below "subsistence level of funding" necessary to carry on commitments already made.

Several speakers at panel discussions said part of the difficulty in developing rational federal spending policies in the field of drug abuse lies in the inconsistency of federal-state relationships.

"We have states who feel very free to come to the federal government and demand that they should receive more federal funds," said Besteman.

"Texas, for example, appropriates out of state revenues $103,000 per year for drug abuse. They receive at least seven million dollars of federal funds, and some people claim they get as much as $12 million.

"In effect, it's the counties in Texas that put up the matching money, the state does not."

Besteman noted that California has a "sort of 50-50 arrangement with the federal government, and in New York they obviously put up more money at the state and local levels than the federal government puts in.

"When you have such a variety of reactions from three large and significant states, it is very hard to define one single unvarying federal policy respecting how the federal level is going to interact with the states," said Besteman.

In response to a discussion about such inequities, state program director from South Carolina, William J. McCord, former ADPA president, urged that development of formula grants be based on incentive, so that a state willing to do more for itself would receive a better reward from Washington.

"I can't see Uncle Sam rewarding mediocrity in the way of state support for alcohol and drug abuse," said McCord.

Another major issue complicating existing federal-state funding relationships was the artificial "separatism" imposed on the alcohol and drug field, said Dr Don Ottenberg, director of Eagleville.

There is a problem more fundamental than the lobbying strength of the constituency that is going to determine the future course in this field, said Dr Ottenberg, and that is the nature of the field itself.

"The fact that it is soon going to become impossible to live by NIDA's rules (NIDA will fund only for non-alcohol problems while NIAAA will not fund for non-alcohol dependencies).

"You're not going to be able to determine a primary drug abuser and exclude alcoholism."

The overlap between the two is tremendous . . . people switch from one to the other, said Dr Ottenberg.

Alberta names agency chief

EDMONTON — A career government administrator with lengthy experience in pharmaceuticals has been selected to head the Alberta Alcoholism and Drug Addiction Commission.

Wilfred J Totten, who has been co-ordinator of special health projects within the provincial health department since February, 1973, becomes AADAC chairman Oct 1.

He succeeds Richard M Anthony who resigned June 30 and moved to Victoria, BC to resume the practice of law.

Totten's new position places him at the head of approximately 350 people employed by AADAC, which is responsible for most treatment programs and public education provided in Alberta. Funded by the provincial government, the commission reports to Helen Hunley, minister of social services and community health.

In 1968, Totten was appointed to take charge of the Saskatchewan government's Alcoholism Commission, an agency similar to the one he will be heading in Alberta. He is married, and has four grown children.

William Fulton of Calgary, vice-chairman of the Alberta Alcoholism and Drug Abuse Commission, continues in his appointment. He and Totten are among six provincially-appointed commissioners who direct AADAC's functioning and are responsible for broad policy planning.

Great scarlet poppy growing begins

NEW YORK — The federal government has authorized the growing of a seed crop of great scarlet red poppies in Western Montana in an attempt to curtail the country's apparent codeine shortage.

Nearly an acre of Iranian great scarlet poppies has been planted at the Western Montana agricultural research station on a contract with the Merck Chemical Company of Rahway, New Jersey.

The purpose, said Don R. Merkley, station superintendant, is to develop a domestic seed source for production of codeine.

Iran and Turkey stopped selling poppy seeds to the United States approximately one year ago and chemical companies have been faced with a dwindling supply of codeine. (Codeine is used to relieve pain, suppress coughs and as a sedative).

The great advantage of the great scarlet poppy is that it yields a substance, thebaine, that can be used to make several narcotic drugs, particularly codeine.

Unlike the opium poppy, the current natural source for codeine, the great scarlet yields little or no opium, the raw material for morphine and heroin.

Cultivation of the great scarlet is supported by the American Medical Association, pharmaceutical and government officials as a safe alternative source of codeine. At the same time, warnings have emerged that the great scarlet has potential for mass abuse (**The Journal**, September 1975).

Thebaine, the poppy's principal extract, is not itself a substance of abuse.

The concern rests on the fact that thebaine can be easily converted into abusable substances far more potent than heroin.

The warning has been most sharply sounded by Dr Sidney Archer, a professor of chemistry at Rensselaer Polytechnic Institute in Troy, NY.

While "neutral" on the question of whether great scarlet poppies should be cultivated industrially, Dr Archer said their "potential" for abuse needs to be taken carefully into account.

Dr Archer states categorically that "anybody who can make LSD can make" powerful drugs of abuse out of thebaine — if, of course, they can get the thebaine. The processes, he said, are cheap and simple — and some potent substances could be made by an undergraduate student with a year's course in organic chemistry.

The formulas, he said, are no problem, because they are widely available in the open, published chemical literature.

The abusable substances he fears may be made are called Bentley compounds. They are easily made, Dr Archer said, because one of thebaine's carbon rings is highly reactive with other substances and so is susceptible to a whole series of reactions that create ever-more-potent drugs.

Thebaine can be combined with an easily purchased chemical, methyl vinyl ketone, which is related to the monomer from which Plexiglas is made. "This is very easy to carry out," Dr Archer said, and yields a compound that is 100x morphine.

By adding a second, "very common" chemical reaction — a Grignard reaction — the potency of the final product can be raised to 500x.

This process could be done with $20 to $50 worth of chemicals — other than the thebaine — in a week, Dr Archer said.

"Any undergraduate can do it if he's had a good first year course in organic chemistry," Dr Archer asserted. "If you have a hydrogenation apparatus, which you can buy, you can convert [another] 100x compound [derived from thebaine] to one that is 3,000x. This requires a little more sophistication. But it also is within the competence of an undergraduate chemist."

Archer continued:

"If you want to go one step further, you can cook up this compound in a solution of diethylene glycol [which is like antifreeze] and caustic potash.

"It's simple. All you need is an electric heating mantle. And it's cheap."

The chemical that results has 12,000 times the potency of morphine. It thus is 6,000 times more potent than heroin.

This substance is related chemically to a commercially manufactured substance, Etorphine, or M-99, that is sold to zoo keepers and game managers. A few drops in a hollow dart, shot from a gun, will stop a charging elephant in its tracks. Etorphine is made by chemicals workers in Britain, and apparently also is now being made in the US. Anyone who could make Etorphine could turn thebaine into potent, potentially abusable Bentley compounds, Dr Archer said.

Pharmacologist Dr William T. Beaver of Georgetown University in Washington DC agreed that anyone with a kilo of thebaine could make Bentley compounds in his basement. A chemist colleague at the National Institute of Health, Dr Everette May, said the thebaine route to codeine "could be fraught with danger".

These are "potential" dangers, Dr Archer stressed, "not prognostications." There is no certainty anyone will make or abuse thebaine derivatives, or that the thebaine with which to do so will become available through great scarlet cultivation for codeine.

The apparent risks, he said, must be weighed against the apparent benefits.

ANNE MACLENNAN reports from the 5th International Conference of the International Association for Council on Alcohol and Addictions, held in London,

Drugs rival alcohol as driving hazard

ALCOHOL PROBABLY mixes less dangerously with driving than most other drugs and a dramatically increased number of young people might be killed in highway accidents if other drugs were as available to them as alcohol is.

This is suggested by a two-year study by the Addiction Research Foundation on Ontario, entitled Drug Use and Driving Risk among High School Students.

Dr Reginald Smart, associate research director of ARF and co-author of the study with Dianne Fejer, told this international audience that on the basis of the study, "alcohol appears one of the less dangerous drugs.".

Two or three times as many users of LSD, other hallucinogens, or tranquillizers report accidents under their influence as users of alcohol under alcohol influence, he said.

"When the data are expressed as a percentage of drivers, alcohol is far more commonly mentioned. But, when they are a percentage of users of a given drug, it is not.

"At that point", he said, "the most dangerous drugs appear to be LSD, tranquillizers and stimulant."

The study was part of a larger survey of drug use among Toronto high school students conducted every two years from 1968. It involved some 1538 grade 11 and 13 students, 710 of whom had driven in the past year. Data were collected by means of an anonymous questionnaire which covered 12 drugs.

Only 2.7% of all drivers had an accident under the influence of alcohol and this exceeds the total for all other drugs combined (2.0%), each of which is of minor importance separately considered, (less than 1% of drivers).

"However, when those with accidents are expressed as a proportion of users, alcohol appears one of the less dangerous drugs."

The study showed about 56% of drivers drink and drive whereas only from about 1% to 6% drive after drug use. While 1% to 2% of drivers report driving as often as three times after drug use, about 34% report drinking and driving this often.

"It would appear that drinking and driving is nine to 60 times as common as any type of drug use and driving...Driving is most common under the effects of tranquillizers although drinking and driving is still nine times as common."

Dr Smart allowed that, overall, drugs such as hallucinogens, tranquillizers and stimulants are relatively unimportant, compared to alcohol, in the accidents of high school students.

"However, this may be because of their infrequent use: Such drugs involved only 5% to 8% of students as users.

"Any social or legislative changes which resulted in increased drug use would be likely to lead to higher accident rates for them."

Archer Tongue, ICAA director, with Dianne Fejer and Reginald Smart

Street drugs

Buyers get rooked

BUYERS OF street drugs are getting roundly rooked much of the time, according to a California study.

"Twenty-three months and approximately 4,700 street drug analyses later, the misrepresentation of street drugs still continues," according to the study by Drs John K. Brown and Marvin H. Malone, professors of pharmacology at University of the Pacific in Stockton.

In a paper entitled Five Years of Non-forensic Street Drug Analyses, the team said the alleged material was actually present in only 59% of 4,700 samples.

Even then, the actual amount present varied considerably.

Only 15.7% of the alleged mescaline samples contained any mescaline as compared to the alleged LSD samples where 92% did have various amounts of only this compound.

Only 15.6% of alleged psilocybin submissions contained some psilocybin and these were mushrooms in every instance.

Of alleged THC submissions, no authentic material has been found.

Thirty-three per cent of alleged amphetamine samples contained various amounts of either amphetamine or methamphetamine and 65.8% of the alleged cocaine samples contained varying amounts of cocaine as the only active ingredient.

Approximately 75% of alleged MDA submissions contained some MDA.

Ninety-seven per cent of the marijuana samples, 91.6% of the hashish submissions and 94.4% of the Hash Oil samples were derivatives of Cannabis sativa.

Heroin was detected in 79.5% of the alleged heroin samples and 53.2% of opium submissions were identified as opium.

"Alleged pure THC, the quintessence of Cannabis sativa, is still offered by the 'reliable' street drug dealer.

"However, this compound in pure form is still not available on the United States, Canadian or European street markets.

The most frequently identified compound in alleged THC samples was the tranquillizer anaesthetic phencyclidine; 170 samples (90%) relied on PCP to act as the active ingredient.

The team said cocaine is the current "high status" drug and probably one of the most expensive commodities on the illicit market with current market price being from $1,300 to $2,500 per ounce "regardless of whether the product is 89% cocaine, three per cent cocaine or 96% procaine".

"This high selling price for illicit cocaine probably is the major incentive for the dealer to reduce the amount of cocaine in a sample, to adulterate with a local anaesthetic, or to sell some other drug as cocaine."

Approximately 66% of the cocaine samples analyzed contained various amounts of cocaine only; approximately 24% were cocaine mixed with some other drug (most frequently a local anesthetic) while the remaining 10% contained some other drug or no drug at all. "The toxicity of these mixtures is probably minimal if inhalation is the route of administration but could be serious if injected."

Labor room clue seen

STRANGE BEHAVIOR in the delivery room could point to a need for a pregnant woman to have a blood analysis before she receives the standard drugs used during labor.

Dr. Celia Viets, director of the Eastern Ontario Poison Information Centre in Ottawa, told the conference of a mother who mainlined what she thought was "speed" to get rid of her labour pains.

This fact was not known in the delivery room, although the nurse noted the patient to exhibit some "strange behavior". During labor the mother received Demerol, Atarax and Lidocaine.

Her baby was lethargic at birth and was noted to be tremulous with spontaneous jerky movements.

Analysis of the mother's and baby's blood and urine were positive for the drugs given to the mother during labor but also revealed Phencyclidine in both mother's and baby's specimen.

(Phencyclidine, developed as an intravenous anesthetic for human use, was discarded because of undesireable side-effects and is legally marketed now only as a general anesthetic for use in veterinary medicine.)

The baby was treated conservatively with no drugs and recovered within 48 hours.

"In retrospect, this mother should have had analysis of her blood before receiving any of the standard drugs used during labor in view of her behavior in the labor room," said the Ottawa doctor.

Dr Viets also described a case in which an infant was brought to emergency in a coma.

On admission, the parents volunteered the information that they had had a "hash" party the previous evening and the child had been found playing with one remaining hash cube on the afternoon of his admission. The paper which had contained the hash was empty.

The child remained in coma for 12 hours and had a mild tachycardia for 24 hours.

In another case, a mother and child of seven years arrived at emergency with abdominal pain and nausea. They were thought to have food poisoning until it was discovered they had inadvertently eaten some chocolate cakes made by a teenager in the family and containing hashish.

The seven-year-old required hospital admission with gastrointestinal symptoms and a tachycardia which persisted for 18 hours.

Coma from excessive intake of hashish has been documented in the literature including one case of coma with tachycardia.

The Poison Information Centre is in the Emergency Department of Ottawa Civic Hospital.

South Africa

It's ripe for addictions

SOUTH AFRICA is ripe for "a great deal of addiction", a Black American drug expert warned here.

Dr Beny J. Primm, executive director of Addiction Research and Treatment Corporation in Brooklyn, said although he has not visited South Africa, the conditions he has seen in films and read about "are all factors which predispose people to take substances to become what they cannot become in reality."

Where there is apparently little hope of rising above the situation into which one is born, where people are immobilized because of a political system, and where prejudice is rife, drugs allow a person "to imagine yourself a king and be a king".

He said availability of drugs would be a particularly crucial issue in South Africa.

Dr Primm was replying to a statement by Professor H. Grant-Whyte of Natal who suggested addition is not yet a problem in South Africa but that some doctors and nurses habitually use pethedine and demerol.

"Possibly the reason only doctors and nurses and people of our profession take it is because of the availability of the substance," said Dr Primm.

Predators at the wheel

SOME YOUNG people who kill and get killed in highway traffic accidents could be labelled Playful Predators, says US sociologist, Dr Irving Babow.

The Playful Predator usually rides with a peer group and intentionally tries to victimize and threaten others by deviant driving "for a possibly lethal kind of fun", said Dr Babow of California Polytechnic State University, San Luis Obispo.

He referred to suggestions by sociologists that there is an increasing kind of illegal behavior, especially by delinquents, in which crime is a form of sport or play, is nonutilitarian, and is aimed at excitement and thrills through breaking the law or a display of juvenile daring. Such behavior includes car theft or stealing but does not stem from need or compulsion.

"In the context of drinking-driving, however, the Playful Predator seems part of the subculture of violence. The 'cat and mouse' game which he and his friends play of harassing other drivers often includes a strong element of hostility and aggression toward strangers and for no utilitarian purpose.

"It appears this type of drinking driver is generally experienced in both drinking and driving and in combining the two," he said.

Although drinking drivers under the age of 25 years comprise a substantial proportion of drivers in alcohol-involved highway collisions and in arrests for drunk driving, Dr Babow said little attempt has been made to differentiate the subgroups and develop a typology which might be helpful in delivering appropriate services and in devising strategies for intervention.

He tentatively suggested 13 types, each of which might require different services and different intervention strategies.

In addition to the Playful Predator, they are:

• The novice drinking driver:
a) inexperienced at driving, inexperienced at drinking and inexperienced at combining drinking and driving;
b) experienced in drinking but inexperienced in driving and in combining driving and drinking;
c) experienced in driving but inexperienced in drinking and in combining them.
d) experienced in driving and experienced in drinking but not in driving-drinking.
• Conbination of drug-using and drinking driver:
• Suicidal equivalent:
• Spree drinking driver:
• Drinking driver with psychiatric disorder (other than sociopath):
• Skillful driver — chronic compulsive sociopathic drinker:
• Aggressive sociopathic driver — not compulsive drinker:
• Aggressive sociopathic driver and chronic compulsive sociopathic drinker:
• Drinking driver especially sensitive to the effects of alcohol:
• Drinking driver who occasionally drives with blood alcohol level too high; usually not problem drinker or problem driver:
• Drinking driver experiencing a stressful life event prior to the drinking driving episode:
• The stress-seeking drinking driver with defectively functioning ego.

Accident and Traffic Medicine and the 3rd International Conference on Drug Abuse of the International England—Travel for The Journal provided by AIR CANADA.

Black program director says

Methadone--'not a political tool'

VIOLENT OPPOSITION to methadone maintenance as the "white man's tool to enslave" minority groups is not necessarily unwarranted, according to the Black director of a methadone program in New York.

"I could use it as a political tool," Dr Beny J. Primm of the Addiction Research and Treatment Corporation in Brooklyn told an international audience here.

"There are many devious ways one could (use it). It is quite possible. But, I don't think it is being done. And I don't think our government is involved in any conspiracy of that nature."

He was referring to charges made occasionally in the United States, particularly by Black radical groups, that by offering methadone as a replacement drug for street heroin, the white establishment is ensuring its own control over minority groups such as the poor and the Black from which many US addicts spring.

Dr Primm said that as a Black, his own decision to support methadone maintenance for addicts has caused him some personal torment.

He said he underwent "a great deal of mild cruciflxlon" and was labelled, among other things, "a handkerchief-head black and a nigger as the term is often used in my country".

However, while methadone "is not all it's cracked up to be" and long-term effects of even small doses are far from being sufficiently understood, its advantages outweigh its disadvantages at present.

As a result of methadone maintenance programs for addicts, there are fewer surgical problems, fewer deaths and fewer altercations with policemen, for example, he said.

He urged further research into the drug's effects and said his own agency is sponsoring a neurophysiological study to investigate effects of methadone administered directly into sub-primates.

However, he said, there must be continued questioning of the use of any particular method of treatment especially for minority groups not only by radicals but by the public at large and by governments.

Drivers still go for ethanol

NEARLY 90% of 135 people arrested for driving while intoxicated but having negative or low blood alcohols on breathalyzer testing, showed the presence of drugs and or alcohol on blood analysis.

And one or more drugs were detected in almost three quarters of the cases, reported Dr James C Garriott of the Southwestern Institute of Forensic Sciences, Dallas, Texas.

Ethanol was detected most frequently with methaqualone, secobarbital or pentobarbital, the mixture of amobarbital and secobarbital, and diazepam, being the five most frequently detected drugs.

Significantly, said Dr Garriott, diazepam became the most frequently detected single drug substance in 1974 (22.5%) whereas in 1973, methaqualone was found in 28.2% of the cases and diazepam in 6.2%.

Sedative or hypnotic drugs accounted for the majority of drugs detected except for one instance each of amphetamine and methamphetamine.

Thirty-nine cases had two drugs, eight cases involved three substances and three had four substances.

Seventy-two per cent of all cases were positive for one or more drugs while 87.5% were positive for either drugs or alcohol.

A comparison of arrest statistics for the two years between those people driving under the influence of drugs (DUID) and those driving while intoxicated (DWI) showed the average age of DUID arrestees to be considerably lower than that of the alcohol group.

Finnish driving study

Diazepam effect confirmed

SUGGESTIONS THAT both diazepam and pethidine may impair driving ability for several hours have been confirmed by a Finnish study.

The drugs have a significant effect on the skills even of young healthy drivers and might well produce more profound impairment in old or ill patients, according to Dr Kari Korttila of the University of Helsinki.

Until now, Dr Korttila said, reports of delayed tiredness and impaired performance after these drugs have been based largely on subjective assessments of patients or doctors.

The Helsinki study was conducted to provide objective data by measuring skills related to driving after subjects received diazepam and pethidine intramuscularly, said Dr Korttila of the departments of pharmacology and anesthesia.

Diazepam administered intramuscularly is commonly used as a sedative and anxiolytic drug in ambulatory patient care, for instance for minor outpatient procedures and dentistry. Subjective tiredness for as long as eight to 10 hours after its injection has been reported.

Pethidine is a commonly used narcotic analgesic and patients receiving the drug are usually told to avoid driving because it is believed to impair psychomotor skills and cause euphoria.

Main conclusions of the Helsinki study were that patients should not drive or operate machinery for at least seven hours after receiving 10 mg diazepam intramuscularly and for 24 hours after receiving 75 mg pethidine intramuscularly.

"One must remember that the results of the present study were obtained with young healthy subjects.

"The effects of the drug in old or ill patients could be more harmful and more prolonged," said Dr Korttila.

Eleven student volunteers, eight men and three women, received diazepam, pethidine or a saline solution placebo three times in a double blind cross-over trial with a two week interval between doses.

Subjectively, the volunteers said pethidine induced the most unpleasant feeling and the greatest sedation and fatigue. Their own conceptions of their driving abilities were most pessimistic from one to five hours after pethidine but seven hours after the injection, nine of 11 subjects given either diazepam or pethidine considered their driving ability to be normal.

Both diazepam and pethidine significantly impaired cumulative reaction times when compared with saline solution. Reaction times remained significantly worse for as long as three hours after pethidine and five hours with diazepam.

Both also impaired coordinative skills with mistake percentages five hours after both drugs still significantly higher than after saline solution. After seven hours results were similar after each treatment.

The ability to discriminate flickering light after pethidine was significantly worse for three hours after the injection and had not reached the level of saline solution at seven hours.

Five subjects tested with pethidine were allowed to practice for two hours on tests to obtain a constant level of performance. They were tested before and then 12 and 24 hours after pethidine.

Twleve hours after the injection, coordinative skills were significantly worse than at preinjection but at 24 hours, all the results were similar to those before the injection of pethidine.

The 6th International Conference for Accident and Traffic Medicine will be held in Melbourne, Australia January 31-February 4, 1977

Teaching 'safe' drug use to some may be one option to abuse

LONDON — Some people who insit on abusing drugs might be better off if they were taught how to do it — safely.

This is the opinion of Dr Beny J. Primm, executive director of Addiction Research and Treatment Corporation, Brooklyn.

He said disciplined use might be the most desireable option for people who are chronically unable to remain drug-free and for whom exhortations to do so are almost meaningless.

At the same time, he said, disciplined drug use might provide a welcome escape route from street life.

Dr Primm said he had participated in a seven-day "think tank" session in Germany on cannabis. At the centre where the international meeting was held, regular clients were allowed to smoke cannabis but within certain limitations imposed by staff.

Opposed at first, at the end of the seven days "I saw it as a viable alternative" to uncontrolled, chronic use.

Such "safe" use might allow some addicts to lead a more normal, productive life although their drug use should not be allowed to interfere with other people.

He said about 20% of the people in his methadone program would probably "do well in a program like that — exceptionally well".

Beny Primm

Alcohol safety courses

Offenders do show attitude shift

ALCOHOL SAFETY courses should concentrate more heavily on convincing clients that drunken driving is a matter of social concern and that the drinking driver violates a responsibility to himself and to society.

They should also emphasize that the individual has it within his power, if he determines to do so, to avoid drinking and driving.

These are among the main conclusions of an American study of the effects of participation in an alcohol safety school on the attitudes of people charged with driving while intoxicated.

The study was performed by Dr Robert H Breinholt, University of Pennsylvania, and James J Breslin, director, Safe Driving Clinic, National Council on Alcoholism, Delaware Valley Area, Inc.

They noted here that both notions have "face validity as being deterrents of Driving While Intoxicated (DWI)".

The American team said that while people charged with DWI are often referred by the courts to alcohol safety schools, studies in changes in DWI behavior have produced mixed evidence on the question of whether participants in safety schools are subsequently less likely to drive while intoxicated or have fewer accidents.

If such courses are to be effective, the first requirement is that they must succeed in changing attitudes so that participants emerge with attitudes inconsistent with such behavior.

To measure changes in attitudes to DWI by participants in a four-session alcohol safety school, an attitude scale was administered to groups of DWI offenders referred to the course rather than to trial.

The scale was given twice to 319 people charged with DWI in Philadelphia — at the first and fourth (last) weekly session respectively. It was also administered at the beginning and end of a similar interval to a control group of DWI offenders who did not participate in clinic sessions.

Subjects showed a change in attitudes toward previously obtained non-offender norms more frequently than control subjects.

Problem drinkers showed more extreme attitudes in the pre-test, relative to the non-offender norms, than did social drinkers.

"The findings support the hypothesis that DWI offenders who attend the four session alcohol safety school show a change in attitudes toward the non-offender norms.

"They also support the hypothesis that DWI offenders who are problem drinkers hold more extreme attitudes than offenders who are social drinkers," according to the team, although findings on serious problem drinkers were inconclusive.

Findings do not indicate that attitudes are more resistant to change the higher a subject's alcohol impairment level.

The study suggests that DWI offenders generally respond in ways that indicate relatively permissive attitudes toward DWI.

"They express more agreement with the notion that drinking and driving is a person's own business, that is is a relatively inconsequential offence that is sometimes unavoidable, and should not be dealt with harshly, particularly if no damage is done."

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Fiscal reality knocking at door

THE CURRENT upheaval at the CFADD (page 1), and the stringent belt-tightening at the US federal level, are both clear enough evidence that anyone aspiring to a career in alcohol and drug abuse fields had better have some basic training in survival techniques.

Committment, innovation, and creativity are all admirable qualities for personnel in this field. But unless vocational ideals can be matched with the hard, cold facts of fiscal reality, drug and alcohol workers may as well go back to reading Alice in Wonderland.

As the Master of Ceremonies in Cabaret so deftly summed up his view of social priorities: "Money makes the world go around, the world go around, the world go around."

Sad, but true. And anyone remaining oblivious to that contemporary credo should start writing his resume.

In the case of Dennis Taylor, who had visions of recasting the CFADD into a high-profile, national role, the aspirations were celestial, the money non-existent.

As Taylor saw it, the CFADD was to become a populist movement, involving individuals, the general public, and workers in the alcohol and drug field. It was to become a focus for national, non-government activities.

That in itself, was a challenge, given the disparity of interests, viewpoints, and philosophies of organizations at the grass roots. Consensus is just as elusive down there, as it is in the halls of the mighty.

In a way, Taylor was trying to play both ends against the middle — calling for a national, non-governmental vox populi — while still insisting on government money via NMUD. It really would have been a quixotic relationship.

At the same time, Taylor must have found out that depending on the private sector for sustained monetary support in times like these and in a field as nebulous as drug abuse, is risky.

Canada's Council on Drug Abuse (CODA) started out with munificent pledges of support from private industry: Washington's Council on Drug Abuse was launched on the massive resources of the Ford, Carnegie, and other wealthy foundations.

Now, both are feeling the sting of parsimony.

The CFADD seems to think it can fare better in harvesting a crop of private money. Good Luck.

But before the new leadership of the CFADD starts knocking on doors, it ought to have some pretty clear answers about what its role is and about what it can do that other organizations (particularly NMUD) cannot or will not do.

It has to justify its reason for being, and it must be accountable for its actions.

And while the CFADD is struggling with its own identity crisis, it would not be a bad idea for NMUD to clearly define its own terms of reference and provide a public accounting for what it does.

Government should be just as accountable as privately funded organizations. After all, there is no such thing as government money.

The money people get from government is the money they send to government, minus freight charges both ways.

To our readers

When The Journal was established over three years ago, our prime objective was to make the publication available to all those with an interest in alcohol and drug dependency. We felt then, and still do, that The Journal would assist's peoples' understanding and, moreover, help them in their work.

Consequently, we developed a mailing list of approximately 50,000 people, the large majority of whom resided in the Province of Ontario.

In order to assist us reach only those individuals who now find the publication of value, we are asking our Ontario readers to demonstrate their interest.

It is our hope that the present Ontario campaign will result in a more effective mailing list, one that ferrets out non-readers but maintains present and potential new readers.

We, in turn, will get to know more about our specific audience and will be in a better position to more effectively gear The Journal's content to that audience.

We sincerely look forward to your continued interest and support . . . GS

Letters to the Editor

Sir:

The headline on the front page of **The Journal** (September 1975) 'Schools, media are scapegoats" caught my eye and my initial reaction was anger.

Sure, a "short lived campaign" (as in election time) as Dr Cahalan called it, is useless. But our centre has always been active in a "genuine movement toward moderation that enlists the energies and hopes of large numbers of people at the grass-roots level."

It is so easy to dismiss small attempts with big, heavy and almost ridiculing words.

Then Dr Cahalan goes on to say: "Only a large scale movement would provide the person-to-person evangelizing that could crystalize the social norms which would enforce moderate drinking behavior" — Whenever does one get a large scale movement without starting small?

At our centre, we have called that a movement to "Attitudinal Change" and we try to get that "peer-pressure" starting at the schools and through the media.

If we can help young people to make a decision *not* to follow the older generation in their often hypocritical behavior in regard to alcohol abuse, and *not* to accept the abusers, we firmly believe that schools and media are a very powerful way to get that "large-scale social movement going."

If it is true, as Dr Cahalan stated, that Jews have relatively few drinking problems, then it is just because in their circles, abusers are *not* accepted. With that in mind, we work hard through schools and media to get a social attitudinal change from "cover-up" to "not accept." We like to call this "prevention."

I was amazed that Dr Cahalan used that same word "attitudinal change" (page 6 of the same issue), as being necessary for problem drinkers. I say, that is too late!

I am absolutely convinced that an attitudinal change has to come about in our total population and not just in the problem drinkers. In them one might call it "cure" if you wish, while we prefer "prevention."

Anthony van den Bosch (MSW)
Centre Director,
ARF, Sault Ste. Marie,
Ontario.

THE JOURNAL welcomes letters to editor

RECENTLY OUR health officials — particularly Canada's Health Minister Marc Lalonde and Ontario Health Minister Frank Miller — have taken to pointing out that some of our diseases are self-induced — by dietary indiscretions, by lack of exercise, by alcoholism and by the taking of other drugs. They have chosen to focus interest on preventive medicine as one means of improving the health status of our citizens, and of preparing us to cope better with health hazards that have become integral to our mechanized life styles.

In the last 10 years, both federal and provincial governments have concentrated heavily upon the provision of curative services, the building of more hospitals, the provision of more beds, and the building of more laboratories and institutions.

Consequently, the re-introduc-

Backgrounder

By GARY SEIDLER

SYNANON: Founded in 1958 by a former member of Alcoholics Anonymous, Synanon has been called just about everything.

- A large vital association of people who share a communal lifestyle;
- A complex and sophisticated organization with tremendous possibilities as a non-profit charitable organization;
- A school for a totally new way of living, with a dream of providing and demonstrating a model society to the rest of the world;
- The most effective drug rehabilitation program.

A US army psychologist, visiting Synanon a couple of years ago, said life there is inevitably reminiscent of Skinner's Walden Two. But, of course, Synanon is not fiction.

Perhaps most importantly, Synanon is *not* comparable to traditional therapeutic communities in the sense that, unlike TCs, it does not present itself as a temporary way-stop which rehabilitates the addict and prepares him for return to "larger society".

Rather, it presents itself as an alternative lifestyle and measures its overall success by the number of individuals who embrace Synanon as a permanent home.

Certainly, to adopt this alternative lifestyle is a drastic step: The Synanon environment is vehemently anti-drug, anti-alcohol, anti-tobacco and anti-crime.

Like the organization he created 17 years ago, Charles "Chuck" Dederich has also been called just about everything — a madman with delusions of grandeur, a saint, an opportunist, a brilliant executive, a modern-day Socrates.

Whatever . . . Dederich, now aged 62, is a force to be reckoned with. In his symbolic uniform of blue denim overalls, he has nurtured Synanon through a one-room storefront in Ocean Park, California, to an organization which boasts many thousands of members, including 1,700 residents at latest count.

It is a rich organization, holding several million dollars worth of real estate around the United States.

Dederich has always maintained that Synanon does not exist exclusively to rehabilitate addicts.

Rather, it purports to teach people from all walks of life to kick all their bad habits, including the "consumer society" blahs.

"Our purpose is to help all people," Dederich said in the late 60s, the heyday of drug abuse, "and not just dope addicts. What the hell is a dope addict today? It's often a kid who can't get to living. He's confused by adolescence and he doesn't buy the values that our generation holds up — get up early and work, and by the time you're 45 you make the last payment on your first house. Who needs it?"

The resident population at Synanon — there are five facilities spotted through California — changes almost daily. Almost 20,000 people have stayed at Synanon since its creation.

Today, approximately 60% are former addicts, alcoholics, delinquents and/or have a variety of other "character disorders". Others come in with no pronounced problems. They simply prefer Synanon's alternative lifestyle.

Synanon has no way of keeping track of what people do after they leave. But, they claim, many have gone on to staff the more than 2,200 drug rehabilitation programs which have emerged over the years.

Generally, it is functional for Synanon to assume that those who leave return to their former lifestyles. This serves to encourage retention and to reinforce the commitment of those who stay.

Success is measured in Clean Man Days; that is days on the job without drugs. During the year ending August 31, 1974, Synanon produced almost 300,000 Clean Man Days.

In other words, for those who stay, and there are many residents with several years membership, the cure rate is 100%.

Synanon is a total community.

Its evolution has meant that every skill and profession imaginable is required. So, it provides job training for electricians, carpenters, heavy equipment operators, salesman, plumbers, secretaries, paramedics, dental assistants, truck drivers, chefs . . .

There is no unemployment at Synanon and the work ethic receives heavy and repeated emphasis.

The large majority of residents work right in Synanon for a nominal wage. Others, called "lifestylers", work out in the community.

There are, at the present time, 290 children at Synanon under age 18. Many of them are offspring of former addicts.

The children are raised in the communal style of the Israeli kibbutz and attend Synanon schools from nursery to high school. One dream, expected to come true, envisages a Synanon university.

Synanon's future may well hang on the success of its "basic training" program for juvenile newcomers. Basic training provides moral, physical and vocational training, and offers parents, teachers, and probation officers an option to juvenile hall.

In basic training, teenagers start from scratch — learn to make a bed, respect their elders.

Economically, Synanon is supported in several ways.

The organization has an advertising gift premium and advertising business, an enterprise staffed totally by Synanon residents who travel in groups marketing their wares to businesses and merchants throughout the United States.

Another major source of income comes from "lifestylers" who contribute most of their income.

But the largest slice comes from individuals and companies who donate good, services and funds to Synanon. This includes newcomers, particularly "squares" — those attracted to Synanon by its lifestyle — many of whom donate their entire wealth to the community when they enter.

The life and soul of Synanon is 'The Game', a leaderless encounter type group activity which is the primary tool for opening lines of communication and resolving differences in the community.

Everyone at Synanon, from children to elders, identifies 'The Game' as the sine qua non of the system.

Dederich contends that the general movement toward development of attack therapy groups, encounter groups, sensitivity groups and the like, had its origin in the Synanon Game.

The drawing out of 'The Game' allows expression from everyone, making it possible, says Dederich, "to resolve their conflicts over differences which normally set them at odds with one another while healing the personality and adopting new and sounder value systems."

In the 'The Game', a group of usually no more than 15, sits in a circle for a no-holds barred free-for-all. Everything and anything is open for discussion. The only prohibiting rule is no violence or threat of violence.

Rage, anquish, joy, compassion are freely expressed with the hoped-for result that better understanding and a feeling of closeness is achieved.

'The Game' is played at least twice a week by all residents, as well as the thousands of non-residents who have joined Synanon Game Clubs in many parts of the country.

The Synanon government is administered by a board of regents under the powerful leadership of Dederich. The government appears highly authoritarian.

"Good boys get good things," is the homely theme stressed by Dederich.

The newcomer quickly observes that ex-addicts and the like prosper at Synanon. They run the place. They prosper because they are committed to good behavior and to becoming competent, constructive members of the community.

Punishment for bad behavior can be banishment, but is usually verbal and meeted out at "The Game."

There are only four basic rules — no drugs (including alcohol), no tobacco, no physical violence or threat of violent action, and every resident must participate in Synanon's aerobic exercise program.

There is no doubt that Synanon provides many opportunities to many once hopeless people.

But life at Synanon also raises one fundamental question: Is submission to its aspects of authoritarian rule worth the advantages of a warm, friendly society apparently free of the social ills of the outside world?

(Next issue — Another view of Synanon)

By Wayne Howell

ACCORDING TO a recent news item, lay alcoholism counsellors in the United States are lobbying for professional recognition and a system of national standards and national accreditation. And according to a recent article in The Journal, Therapeutic Communities (TCs) in Canada are 'coming of age' and are demanding parity of funding with other mental health institutions, licensure of paraprofessional personnel, and community and academic recognition.

Is a revolution brewing? Are gifted amateurs going to get the recognition they deserve and then elbow the professionals out of the field? (What would happen, for instance, if Alcoholics Anonymous became militant and presented a brief to government outlining its success rate over the years and on the basis of that brief AA demanded that henceforth all funds for the prevention and treatment of alcoholism be channeled through the most efficient hands?)

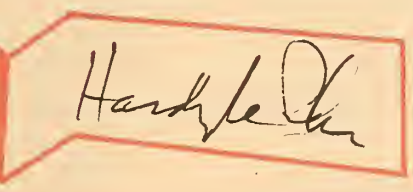
A closer look at the new militancy reveals that there is no cause for alarm — the arteries of these embryonic tax-supported institutions are hardening at such a rapid rate that they shall be as sclerotic as those of more prestigious elder institutions in a matter of years.

For instance, the non-certified lay alcoholism counsellors in the US show mature judgement in their plans for certification — 5-to-10 thousand of them will be automatically accredited without an examination under a 'grandfather clause'. Five thousand is a nice minimum figure to use when striking a deal with a major resort hotel for a Founding Convention — there they can apply themselves to the task of devising an examination rigorous enough to ensure that future members admitted to the organization will not be rank amateurs and unqualified do-gooders who think that just because they had a 'problem' themselves, they know everything.

Looking at the TCs, we see that these organizations whose most interesting qualities are, according to a TC spokesman, 'their ability to be adaptable, flexible and viable', are asking that the Non-Medical Use of Drugs Directorate declare a moratorium on funding of new and unproven projects and funnel the funds into established TCs so that they can achieve their full potential. No sense letting the money go to some upstart amateur group with some new adaptable flexible program that just might prove to be viable! Like other institutions that have 'come of age' before them, they have gotten over the pubescent period nicely and now see the merit in cornering the market and cutting out potential competition.

Senior institutions can also take solace in the fact that as a first priority the TCs — which are largely concentrated in North America — have formed a North American Association of Therapeutic Communities which has already got down to the essential task of planning a conference — in Europe! No wide-eyed radical amateurs here; no disturbers of the status-quo; like other institutions that have come of age before, they see the merit of holding conferences on distant continents. They'll fit right in.

Guest Book



tion of some sense of self-responsibility for the individual's own health is to be commended.

But with talk about preventive health so free and easy and fashionable, we ought to try to define more precisely what we mean by that phrase.

We ought to establish the fact that preventive health means more than watching our waistlines, throwing away our cigarettes, and stopping the bombardment of our livers and brains with all sorts of noxious chemicals.

The field of preventive health is immense. If its full benefits are to be realized, we ought to think of its many component parts and we ought to plan with these diverse components in mind.

If we look at preventive medicine in North America we should certainly consider matters such as the status of women, health services, food, nutrition, agricultural, forest and mineral resources and industrial energy needs.

We should think about urbanization and its effects on people and we should talk about housing, affluence and poverty. We should consider matters such as mental illness and the dominant diseases of affluent countries and affluent groups in poor countries — heart disease, cardiovascular conditions such as cerebral hemorrhage and thrombosis, cancer, diabetes, and chronic obstructive lung disease.

We should think about all accidents, particularly automobile accidents and deaths, and consider at least some of the infectious diseases.

In Canada, we are not at the moment suffering from excess population growth except in some groups such as the Canadian Eskimos. We are suffering from population destruction in the form of 40,000 abortions which we do per year. It seems neither reasonable nor humane to be so irresponsible as to make it necessary that there should be killing of these fetuses every year. Both men and women should have the sense of responsibility to use contraceptive devices rather than to rely upon abortion as a method of birth control.

In our study of personal preventive medicine we should look at things the individual patient can do to protect his or her health. We may start with a child conceived by loving, well-nourished and healthy parents.

We should study the whole question of prematurity and associated low-birth weight in which there is an increased incidence of mental retardation.

During infancy and childhood, a great deal can and should be done, not only to see that children are well-nourished, but to see they are immunized against the conditions against which immunization is possible.

People are accustomed to thinking about diphtheria, whooping cough, tetanus and polio, but tend not to consider German measles, measles, or even mumps.

Growth of children is also important. Parents should know about psychological growth and realize a happy home makes for greater mental health. When parents are fighting, or drunk or generally misbehaving, this obviously has a deleterious effect on children. It is also sad to see so many divorces in our community. They contribute to a decaying and disruptive society.

There is a definite possibility such deterioration can be stopped. If we grow poorer and have fewer material goods, possibly we would devote more time to the essential things of life — love and helpfulness and hard work, some of which are regarded now as old fashioned and outdated qualities.

Many people feel, with considerable justification, that many types of cancer have an origin in the noxious materials in our environment. We have recently been told about lung cancer associated with asbestos. We have known for very many years that substances derived from coal tar and its derivatives can cause cancer.

We have merely touched here upon the broader aspects of prevention, particularly personal preventive medicine. We believe that, in some respects at least, many people are responsible for their own state of health; that many people make themselves sick by the way they live and by the way in which they behave.

Fortunately governments are learning, albeit slowly, that prevention, in at least some instances, costs less than treatment. It makes sense, therefore, that we combine both treatment and prevention in our health systems.

(Dr. W. Harding le Riche is Professor of Epidemiology, Faculty of Medicine, University of Toronto.)

'Program for life' begins in kindergarten

Long-term study launched

CHILDREN IN four Toronto schools are starting a unique program this fall to see if daily sessions in building a positive self image will affect their later abuse of chemicals.

Pupils from kindergarten to Grade 4 will take part in 15-minute sessions with their teachers at the start of every school day.

The format has been designed by Margaret Sheppard, community consultant at the Hamilton office of the Addiction Research Foundation of Ontario, and a former school teacher. She plans to do an eight-year follow up, using comparable schools that don't have the program to assess any differences the program makes in the pupils' choices about smoking, drinking and other drug use in their early teens.

Although it is aimed primarily at preventing later abuse of alcohol, Mrs Sheppard sees it as "a program for life, to cope with all kinds of life situations and to enjoy life."

"For 15 minutes every day, children will talk about who and what they are, how they fit in the scheme of things, and where they would like to go."

For the first years, the sessions will deal with what children have in common, how they are alike, and how they all have specific needs, wants and feelings. "This is the concept of I am not alone, and it's okay to be the same," Mrs Sheppard explained. Children will realize that others have the same fears they have, and they can perhaps alleviate them by talking about them.

Later, the emphasis shifts to differences. "I'm the only me in the world and I should protect that uniqueness," is how Mrs Sheppard summed it up. "It will deal with how to be proud of myself, how to look after myself, and the concept that it is fine to be unique as long as you don't violate another's space. It's okay to drink if you want, but don't drive and drink."

Part of the positive self-image is developing a respect not only for one's abilities, but for limitations as well. "We can't all be our own doctors and lawyers. It takes special people to do special things, and there is pride in any occupation."

Mrs Sheppard said there is nothing new about the concept of teaching children to be positive about themselves . . . "It's been around as long as teachers have, but not in this concentrated way. This makes sure that once a day a child has his ego boosted slightly.

"If it works, I think we'll start to see changes in two years." Both the study children and the controls are being pre-tested for self-image, and these tests will be repeated periodically. "If there isn't any appreciable impact in self-image, we can revise the program as we go along."

The kindergarten to Grade 4 program is only a part of a wider one that goes up to Grade 8, and deals with clarification of values, problem-solving and decision making. These more sophisticated concepts are already in use in some Hamilton high schools.

The values clarification section is now aimed at Grades 5 and 6. "It's designed to get us to look at ourselves in relation to our value system. Do we act out our values in our behavior? If our behavior is inconsistent with our values, we are uncomfortable and feel guilty and we don't know why."

For Grades 7 and 8, "we develop a model of decision-making and problem solving so when you're faced with a life-changing decision you can make it knowing what you're going into. We don't teach that today," said Mrs. Sheppard.

"For example, take a party situation where everyone is drinking. Are you going to take a drink? We want to deal with how you feel about it now, before you get in that situation, so you will have thought it out before. If you decide not to drink, you will have the inner resources to stand up to that decision. If you decide to drink, you will probably drink responsibly because you have thought it through clearly, and won't feel guilty about it."

Margaret Sheppard

BETTY LOU LEE reports from the Institute on Addiction Studies in Hamilton, Ont., sponsored by Alcohol and Drug Concerns, Inc.

Stress the positive says Ontario group

THE TEMPERANCE movement has come a long way from the days of taking the pledge: Now, among other things, it teaches how to use credit wisely.

And what has credit use got to do with the sane use of chemicals?

It's indicative of the whole new approach to prevention of addiction being taken by Alcohol and Drug Concerns, Inc., a citizen's group in Ontario whose theme song could be "Accentuate the Positive."

Bill Robson, 28-year-old director

Bill Robson

of youth work with ADC, sees it as an attempt to help young people develop skills in handling their lives, and show them there are optional lifestyles to the abuse of chemicals, whether they be tobacco, alcohol, street or prescription drugs.

One new program that has been tried to a limited extent in Metro Toronto schools is presented to school assemblies of students in grades 8 to 13. Forty minutes are spent discussing subliminal advertising for smoking, alcohol and patent medicines.

"We get them to look at what's not shown in the ad, not just the parties, the pretty girls and the handsome, rugged men. We hope they develop a greater sensitivity."

Another program that has been tried in a few communities with church, school or social groups is a 10-hour workshop for parents and their teenaged children.

Called Family Communication Days, they represent for some families the first time a parent has spent a whole day talking to his teenagers.

"The program deals with communication blocks and how to dissolve them," says Mr. Robson. "One reason young people turn to crutches is because of frustration in communication.

"There may be some mention of alcohol in the sessions, but we're more likely to be talking about how the guy feels who is six feet tall at 12 years old, or the person who is no good at sports. These are the real growing pains kids have, the things they spend hours knocking themselves about.

"The parents probably don't learn anything new, but they have probably forgotten how they felt when they were that age."

While the adult may truthfully say a broken romance will not seem so tragic a month from now, children live more for the moment. Which is another problem in accepting the desirability of forgoing an immediate pleasure for the long-term benefits.

"Kids live for the here and now, and they are not willing to sacrifice now for more later. They live in a buy now, pay later world, and those kinds of values aren't being instilled by parents."

Toc Alpha, the youth program of Alcohol and Drug Concerns, also has a new focus, away from the preaching temperance theme of old. It too, is placing emphasis on how to acquire life skills, for example, handling money wisely.

Other Toc Alpha programs might be devoted to marriage, being a parent, decision-making, building a self-image, or using chemicals wisely.

"Young people by the time they're 25 years old can be swamped by debt," says Mr. Robson. "Most adults now don't have more than a month's living expenses in the bank. By showing them how to deal with these and other situations, you show them that they don't have to turn to dependency to deal with frustrations and emotions."

Police fear family fights

HALF OF the North American policemen killed while on duty are probably slain while investigating family disputes, a Canadian police officer estimates.

Detective Sergeant Robert Weatherstone of London, Ontario, said he cannot remember responding to a family dispute that did not involve alcohol: Police fear family dispute investigations more than any other type of call.

"Booze and family problems are the worst things you can get involved in. Every call scares you because you don't know what you're walking into. You can walk up to the door and Boom!"

Such calls occupy about half the time of a man on the beat in his city.

London has set up a program with five "family consultants" trained in psychology and social work who work with the department, but are not police officers. An officer may accompany them on a family dispute call if the family has a history of violence or is completely unknown to the force.

The consultants not only calm things down, but also know the community services available to help with the family's problems.

"A uniform walking up to the door often incites violence," Sgt. Weatherstone said. "These consultants (both men and women) are not in uniform, and they aren't big guys. They have taken a big load off the police in terms of time and costs."

Sgt. Weatherstone was critical of partial suspension of licences in impaired driving cases.

Some judges allow a person to drive for work purposes only, and during certain hours of the day.

Sgt. Weatherstone, a police officer for 17 years, said this reduced the deterrent effect.

"A few years ago, it was total suspension, it was a real penalty, and they were really frightened of it. Now, with a successful plea, a guy can get his licence for what he wants it for, and he isn't on the suspension list."

He said partial suspensions are not entered on the computerized list of suspended drivers, so if a driver with such restrictions is stopped by police in another city, they have no way of knowing about the restrictions. A driver restricted to daytime business driving can simply visit another city for social, nighttime use of his car.

He approved the practice of charging hotels which serve minors, rather than the minors themselves and said when his duties included nightly checks of hotels, he might charge as many as 16 minors with drinking while underage. They spent the night in jail, and he spent most of off-duty time in court.

But when the hotels were charged, and had to show the Liquor Control Board why their licences should not be suspended, "that solved a lot of the problem".

Timmins ARF director

Treatment programs need three parts

A TREATMENT program for any individual alcoholic should be tailored to his specific situation, says Dr Paul Humphries, director of the Addiction Research Foundation clinic at Timmins.

But any treatment suit should have three basic components: a didactic education program, group therapy and Alcoholics Anonymous, he said.

"In many cases in the past, the alcoholic was fed into a program with the idea that he would come out cured. But there is probably more than one cause for alcoholism, so we must put the emphasis on the individual and his needs, and build a program suited to him from any combination of the therapies available."

Outlining a myriad of treatment modalities that have been tried, from Antabuse to Zen, Dr Humphries said most of them can claim a long-term success rate of no more than about 30%.

Industrial programs of constructive coercion have been an "outstanding approach" that sometimes result in marked improvement in more than 80% of addicts, "and they certainly have an effect for the employed alcoholic".

Dr Humphries said family therapy as a "cure" for alcoholism has not had outstanding results, but is a necessary and valuable adjunct to treatment programs. He cited studies that showed up to 50% of alcoholics had at least one alcoholic parent as a measure of the need for family involvement in treatment.

Some research indicates that about 10% of alcoholics can learn to drink again socially, controlling the amount, the time, and the situations of their drinking.

But Dr Humphries said the question of controlled drinking cannot be fully evaluated until the etiology of alcoholism is determined. "If it's genetic, then the person probably can't learn to control drinking short of genetic manipulation. If you don't know the cause, how can you make a decision."

Paul Humphries

He said doctors putting alcoholics on medication have frequently been criticized — for providing an added crutch, or setting up a cross-addiction. But in some situations, drugs are definitely indicated, he argued.

As an example, he cited a man whose life is going well, but whose wife dies. Then he loses his job. He gets very depressed, starts to drink, and becomes an alcoholic. "Alcohol use here is not the problem, depression is, and you have to get rid of that. Anti-depressants may be indicated here."

Around the world

YOUNG DRIVERS
People under 25 years who are convicted of a drinking/driving offence should not only be disqualified they should also be required to take a second driving tests, says Alex Durie director general of the Automobile Association in the UK.

SAIGON TRADE DOWN
Thailand has become the production and distribution centre of a drastically revised international trade in narcotics in the aftermath of the Indochina war. US and UN officials say many of the traditional opium routes to Saigon are now closed.

AFRICAN AIR
East African Airways, the airline jointly operated by Kenya, Uganda and Tanzania, is increasing its efforts against employees involved in smuggling narcotics. Several airline employees have been charged with smuggling marijuana from Kenya to Britain. Now, the airline's director-general has asked flight crew and cabin staff associations for their assistance in reporting any members suspected of involvement in drug trafficking.

TURKS CONTENT
UN officials fighting illicit drug trade have reported from Turkey they are "well impressed" by the handling of the first opium poppy crop there since 1972. They found Turkish farmers satisfied with the new system by which they deliver the poppy unlanced to state authorities.

Chemical restraint of prisoners/patients

WHO doctors issue warning

By DAVID EHRLICH

GENEVA — World Health Organization doctors have warned against the indiscriminate or inhumane use of "chemical restraint" on prisoners, including dependence-producing drugs.

In a study prepared for the 5th United Nations Congress on the Prevention of Crime and Treatment of offenders, doctors remind that potassium bromide was used for half a century before the dangers became clear.

These old tranquillizers concentrate in blood and tissues leading to chronic bromide intoxication and exacerbating mental illness, they note. Other substances used were chloral, paraldehyde and early barbiturates.

"Entire populations of psychiatric hospitals were routinely drugged . . . to make them more tractable," the experts recall.

The doctors are concerned about the great range of new drugs that can be used to restrain disturbed detainees in hospitals or prisons.

"No use of minor or major chemical restraint is desirable in itself," the doctors say. They specifically oppose the use of drugs as part of inhumane interrogation, "hormonal demasculinization" or castration, psychosurgery and straitjackets.

The health agency also warns jurists and others that prisoners who are given prescribed drugs for the first time can become dependent by the time of release.

The already dependent offender on admission may require a continued supply.

"Forms of restraint that were accepted within living memory are today regarded as unacceptable," they emphasize. "Today's practices may be repudiated in the future, but . . . they will (undoubtedly) be continued, always under medical supervision, until better solutions are available."

WHO's advisory report was requested by the UN General Assembly. It also reviews the varying legal provisions governing addiction and crime.

"Although there are differences of medical opinion as to the respective merits of institutional and ambulatory treatment," WHO says, "there is virtual unanimity that dependence on drugs, including alcohol, is a form of ill health for which penal sanctions are entirely unsuited." This "applies to the possession and use of a drug *per se*."

In foreign jails

1300 'misguided' Americans

LONDON — More than 1,300 Americans, most of them young, are in foreign jails on charges of use, possession, trafficking, or smuggling of illegal drugs.

A survey conducted with the aid of 120 United States diplomatic and consular posts shows that in the "top 10" countries, 988 Americans are under detention on drug-related charges. The "top 10" are Britain, Canada, Mexico, West Germany, Colombia, Spain, Japan, France, Greece and Peru.

According to a US Embassy official here, many of the offenders initially believe they can be protected by their own government.

They are often shocked to find that not only is this not so but the judicial and penal machinery in most countries differs greatly from that in Britain, Canada and the US. Few foreign countries, for example, provide a jury trial. Bail is accepted in only 12.

Their lack of awareness is despite efforts by the State Department to forewarn prospective travellers of the severe penalties invoked by foreign countries for violations of their drug laws.

The official emphasised Americans are subject to the same penalties and treatment for drug violations as the nationals of the country in which they are arrested.

US consular officers do not finance bail, legal fees or other expenses although they do contact detainees, inform them of their local rights, and help them to get in touch with their families or friends who might provide more effective assistance.

"The (promise of) enormous profits of drug smuggling to the United States has only filled the jails abroad rather than the pockets of these misguided Americans," the US official said.

Meanwhile, in most countries prosecution of drug offenders is being intensified.

Pre-trial detention which may involve solitary confinement for months in primitive prison conditions, tends to be the rule rather than the exception in many of the producing countries.

Penalties for possession or trafficking in any kind of narcotics can mean a minimum of six years at hard labour and a heavy fine in many countries. In a few, such as Turkey and Iran, it can mean the death sentence.

MDs set example

JERUSALEM — Eighty percent of Israel's physicians believe they should serve as personal examples against smoking — and 77% actually do so, according to a new survey by the Ministry of Health's education department.

Only 23% of Israeli doctors smoke today compared to 33% five years ago, and 64% 15 years ago.

Moreover, of those doctors who continue to smoke, 62% want to stop.

About half of those who smoke up to 10 cigarettes (or the equivalent in pipe smoking or cigars) a day, tried to stop during the past year; two-thirds of those who smoke between 20 and 30 cigarettes tried to stop in the past year; and 77% of those who smoked more than 30 cigarettes tried. Most made more than one attempt.

In the general population, 36% of adults and youngsters smoked in 1975, compared to 42% in 1970.

Clergy getting into high gear

By MARY HAGER

BERKELEY, CAL. — There is such a thing as being too successful, Rev. Herman J. Kregel has discovered.

As the architect of a pioneering program to train clergy and theological students of all faiths in the prevention, treatment and control of alcohol abuse, he has watched as the highly trained experts produced by his program have been snatched up to fill roles in community counselling and treatment programs, and have not returned to their parishes as he had hoped.

Mr Kregel, who is director of the Berkeley Centre for Alcohol Studies at the Pacific School of Religion here, has devised a "mini-sabbatical," a three-month program to replace the year-long stipends that have been available for the past seven years, in an effort to combat the problem of too much success, and to produce clergymen who are acquainted with problems of alcohol abuse but are not highly-trained specialists.

He explained that he became interested in the problems of alcoholism during his years as an Army Chaplain and became convinced that the clergy was "the last major untapped resource of professional care-givers and agents of change in the area of alcoholism and other drug problems."

His interest led to a job with the California State Department of Public Health and from there he dreamed up the centre — sponsored by the department of public health, accepted by the oldest theological seminary west of the Mississippi, and primarily funded by the federal government.

Surveys had shown, he continued, that 70% of alcoholics had taken their problem to a clergyman at some point, but that the clergy were able to offer very little help to the alcoholic or to his family. The clergy suffers from what he called "the passionate apathy of avoidance".

Consequently, it was apparent that members of the clergy should be acquainted with the problems of alcoholism and with the resources and treatment possibilities available and should become involved with the problem they had been avoiding, he said.

The year-long program, which can lead to an MA in alcohol studies and was the first program in the world to lead to such a highly specialized degree, was designed so the clergyman would have the expertise to help parishioners in trouble when he returned. Hopefully his interests and efforts would be the impetus or "seed" that would lead to more extensive prevention, treatment and control efforts within his community.

And, Mr Kregel acknowledged, several of the clergymen have returned to their parishes. But others are serving as directors of city/county alcohol programs, directors of education and/or counselling in rehabilitation centres, in the military chaplaincy on special assignments, and as probation officers. One has founded a halfway house for members of the clergy, and two have written books about alcoholism.

The special stipend-turned "mini-sabbatical" is only one aspect of Mr Kregel's program.

A two-week summer school is run every year for 75 clergymen and church leaders, with a few workers in the field included to provide a "good mix."

The center has also sponsored several three-day workshop-/seminars for members of the faculty in institutions that train the clergy, hoping to acquaint these key persons with the problems of alcoholism and encourage them to incorporate alcohol studies into their curriculums, Mr Kregel said.

Rev Herman Kregel

Influential alcoholics pose dilemma

By ALAN MASSAM

GUILDFORD, UK — A British consultant-physician may have caused some red faces in high places when he publicly admitted concern over a dilemma faced by many doctors in the field of treating alcoholism.

The question, asked by Dr Julius Merry, director of the alcoholic unit of West Park Hospital, Epsom, Surrey, was: "What does one do if an alcoholic patient is a person in authority — making decisions affecting other people's lives?"

Dr Merry revealed at the annual meeting of the British Association for the Advancement of Science here that he has two judges among his patients.

He said: "I have been thinking about writing to the Lord Chancellor to tell him how things stand. One sometimes wonders about the ability of such men to pass sentence on others when they may be in a hurry to get back to the bottle."

Earlier, during his formal lecture, Dr Merry said his concern over the decision-making of influential alcoholics sprang from recent statistics showing that company directors were 22 times as prone to cirrhosis of the liver as the average male.

Professional people were inclined to have serious drinking problems and this was shown also by the high representation of social groups in alcoholic patients admitted to psychiatric hospitals.

Dr Merry said the British alcoholic patient was unfortunate since psychiatrists here regard alcoholism as the disease they would least like to treat, and nurses and medical staff generally tend to neglect patients admitted to hospital with drinking problems.

British alcoholics had a hard time obtaining hospital treatment since many doctors demanded that they gave up drinking FIRST. This was rather like expecting recovery before commencing medication. Alcoholics were also often "turfed out" of hospitals if they relapsed and had a drinking bout while receiving treatment.

Dr Merry also produced results showing that performance of tasks was significantly reduced by a much lower dose of alcohol than that "permitted" before a motorist was considered to be "legally over the limit" for charging for a motoring offence.

The stage as a therapeutic tool

By DOROTHY TRAINOR

MONTREAL — A bilingual revue that exposes how ex-addicts felt about their problems before and during treatment has opened to critical approval.

Already, a one-week public showing of the production entitled Metamorphosis has provided Montrealers with an insight into the addict's world through music, skits and dance. The group now plans a tour of city high schools.

The show is the result of months of work entailing the use of theatre as a therapeutic tool in the Portage Program for Drug Dependencies. In the Portage setting at Lac Echo, Que., the project led by Arleigh Peterson and Jean-Gilles Godin involved all residents in the use of movement, improvisation, and confrontations leading to theatrical expression. The most talented theatre students were then selected as the revue's cast.

Mr. Peterson, founder of Montreal's experimental Revue Theatre, directed Metamorphosis and wrote the English text. Mr. Godin, a non-professional resident, served as assistant director and authored the French writing. Michel Phelps, another resident, composed lyrics and music.

"I am highly pleased with the result of our theatre workshop and its product Metamorphosis," states Mr. Peterson who has also worked with addicts in New York City. "Not only did I discover some outstanding talent, but all residents gained some therapeutic benefit.

"These kids need a high to replace the high they found in drugs. They find it on stage," he told **The Journa**l.

The revue opens with Michel Phelps singing, "I was walking on some very thin ice . . . . but it's not that way any more .... I know what it is to be alone....."

A series of skits and interpretative dancing, interlaced with Phelps' songs, makes up the remainder of the show. The message reflects the addict's frustration, anger, loneliness and feelings of rejection.

In one poignant scene, Joan Newton remembers she didn't want to eat Thanksgiving dinner with her "square parents". Instead she sought a high with her friends. The experience of 'scoring' on Thanksgiving Day ended up with their drinking a "a gallon of cough syrup and eating French fries — cold." She queries; "Were we really cool?"

In another Phelps' song about "The Door," he describes his search for a way out of drug involvement. The door is one of opportunity that will open and the realization that some doors stay closed.

But humor is not lacking, despite the serious message of the show.

The program ends with the reading of a letter from a former Portage resident who could not resist a final drug fling. The factual letter was written from prison and describes the death of his girlfriend from an overdose.

The performers meet the public in informal discussion after the show.

John Devlin, executive director of Portage, now plans to extend the activities of the Portage Repertory Arts Workshop into a new "animation" program beginning in November. This will include a theatre workshop of improvisations, playwriting, preparation of productions, etc.

Cast of Metamorphosis . . . production reflects addicts' world

Electro-stimulation superior to methadone treatment:study

By LACHLAN MACQUARRIE

HONG KONG — Dr H. L. Wen, whose 1973 studies on the use of acupuncture in treating withdrawal symptoms aroused worldwide interest, has reported promising results from a study of the treatment of physical dependence on drugs by acupuncture and electro-stimulation (AES).

In this latest study, Dr Wen, consultant and chief of neurosurgery at Hong Kong's Kwong Wah Hospital, has collaborated with Dr S. W. Teo, medical superintendent of the Women's Treatment Centre of the Society for the Aid and Rehabilitation of Drug Addicts (SARDA). They reported their findings to the 31st International Congress on Alcoholism and Drug Dependence in Bangkok earlier this year.

Seventy patients were voluntarily admitted to the Women's Treatment Centre of SARDA. Thirty-five were treated with AES and 35 were given methadone treatment. All of the patients were female and ranged in age from 17 to 67. Age distribution was similar for both modalities of treatment. Patients gave their occupations as housewives, bar girls, prostitutes and procuresses, while some were unemployed.

All of the women had been addicted to heroin for at least two years and one patient had been addicted for 31 years.

The women gave various reasons for voluntarily seeking treatment. Some said they recognized the danger and futility of addiction and some wanted to take on more family responsibility. In other cases, work and health were being threatened. Some patients had no money to purchase drugs and others came to the SARDA's Women's Treatment Centre because of the pressure of police action, an authoritative parent, or a probation officer.

Regarding the technique of AES treatment, the lung points in the concha of each ear were needled and the needles then connected to an electrical stimulator. The voltage used would differ slightly according to the needs and preference of individual patients, but the average ranged between five and six volts. The frequency used was 125 Hertz. Treatment was given to the acupuncture group twice a day with each session lasting about 30 minutes.

The methadone group was given 10 mg. of methadone by mouth three times daily for three days. Subsequently the daily intake of 30 mg. was decreased by 2.5 mg. per day and if, during the next 11 days, the patients were successfully weaned from methadone, they were considered drug-free.

It was found that patients treated with AES stayed in the withdrawal ward an average of eight days, while the average for the methadone group was 14 days.

After members of each group had finished treatment in the withdrawal ward, they stayed a period of from two to four weeks in the rehabilitation ward where they received individual and group counselling and occupational therapy, and where preparations were made for their return to the community. Following discharge, the progress of each patient was followed by after-care social workers, and regular urine and nalline tests were carried out to check if they were still on drugs.

After a one year period of observation and follow-up, it was found that 18 women (51%) treated with AES had abstained from using drugs. In the methadone group 10 cases (28%) abstained.

In pointing to the superiority of the acupuncture method of treatment over methadone, Drs Wen and Teo maintain that these promising results could have been even better if the Women's Treatment Centre had been in a position to offer extended outpatient treatment.

"It is our opinion", they conclude, "that if AES outpatient facilities were available on a 24-hour basis, so that discharged patients could come back for treatment when they experienced a craving for drugs, then the percentage of AES abstinence would be even higher than at present".

New Books

By RON HALL

Drug Addicts In A Therapeutic Community: The Satori Approach

. . . by Vincent P. Zarcone, Jr.
York Press Publishers
(101 East 32nd Street,
Baltimore, MD 21218), 1975.
index: 257p.: $14.00

Of interest to those involved in the treatment of drug addicts, this case history of a therapeutic community provides details concerning daily problems and their solutions. The use, limitations, and values of methadone are examined, and a full program description is provided.

The Prognosis Of Narcotic Addiction

. . . by K. Singer
Butterworth and Company
(161 Ash Street,
Reading, MA 01867), 1975
index: 150 p.: $5.95

In this report of a study of a group of Chinese narcotic addicts treated in Hong Kong and followed up for periods of between 7 and 9 years, the investigators describe the sample and methods, patterns and determinants of outcome, as well as assessing the influence of various factors on outcome. The literature on previous studies is briefly but critically reviewed and the problem area is described.

The Gentlemen's Club: International Control Of Drugs And Alcohol

. . . by Kettil Bruun, Lynn Pan, and Ingemar Rexed
University of Chicago Press
(5801 Ellis Avenue,
Chicago, IL 60637), 1975
index: 352p.: $12.50

This book describes the development of legal and administrative controls over drug production and distribution. In doing so, the authors examine the role of individuals, nations and other groups in formulating policies, and they include a number of proposals for change.

Alcohol: Drink Or Drug?

.. . by Margaret O. Hyde
McGraw-Hill Book Company
(1221 Avenue of the Americas,
New York, NY 10020), 1974.
index: 159p.: $4.72

Descriptions of the manufacture of alcoholic beverages, the problems of alcoholism, the physiological action of alcohol, social drinking, and historical perspectives, are presented in an effort to illustrate the differences between the use and abuse of alcohol.

Our Chemical Culture

. . . by Marcia J. Summers, Dinah Prentice, James G. Trost, Dorothy Feeley, E. Leif Zerkin, and James R. Gamage
STASH Press
(118 South Bedford Street
Madison, Wisconsin 53703), 1975.
134p.: $5.00

Information on categories of drugs including alcohol, cannabis, hallucinogens, inhalants, narcotics, depressants, stimulants and tobacco are presented in this book which is intended for high school students. History of use, dependency, drug effects and available treatments are outlined for each category, and issues such as drug use and driving, legal issues and the quality of street drugs are discussed.

Developments In The Field Of Drug Abuse

edited by Edward Senay, Vernon Shorty, and Harold Alksne
Schenkman Publishing Company, Inc.
(3 Mt. Auburn Place,
Harvard Square,
Cambridge, MA 02138), 1975.
index: 1165p.: $15.00

This publication of the 1974 Proceedings of the National Drug Abuse Conference contains 180 articles concerning drug abuse behaviour from many points of view. Treatment prevention and enforcement, the addicted women and the criminal justice system are only a few of the topics which are discussed.

Other Books Received

Alcohol as a Drug: A Curriculum on Pharmacology, Neurology and Toxicology: Becker, C. E., Roe, R. L., and Scott, R. A., 99p., $14.80.
Research Advances in Alcohol and Drug Problems: Volume 2: Gibbins, Robert J., Israel, Yedy, Kalant, Harold, Popham, Robert E., Schmidt, Wolfgang, and Smart, Reginald G. (eds.) John Wiley and Sons, Toronto, 1975, 348p., $23.10.
Dialogue on Drugs: Laccetti, Silvio R. Exposition Press, New York, 1974, 175p., $6.75.
Cocaine — Its History, Uses and Effects: Ashley, Richard St. Martin's Press, New York, 1975, 232p., $9.95.
The Forbidden Game: Inglis, Brian Hodder and Stoughan, London, 1975, 256p., $17.95.
Narcotics and Hypothalamus: Zimmerman, Emery and George, Roberts (eds.) Raven Press, New York, 1974, 272p., $18.95.
Recovery from Alcoholism: Strachan, J. George. Mitchell Press Ltd., Vancouver, 1975, 127p., $4.25.
Drinking Habits Among Alcoholics: Ahlstrom-Laakso, Salme Finnish Foundation for Alcohol Studies, Helsinki, 1975, 216p.
Nursing Care of the Alcoholic and Drug Abuser: Burkhalter, Pamela K. McGraw-Hill Book Company, Toronto, 1975, 297p., $8.75.
A Season in Hell: Knauth, Percy Harper & Row Publishers, New York, 1975, 112p., $8.00.
Promoting Health in the Human Environment: Meyer, E. E. and Sainsbury, P. (eds.) World Health Organization, Geneva, 1975, 69p.
DWI Law Enforcement Training Project: Course Guide: Carnahan, James E. U.S. Government Printing Office, Washington, 1974, 71p., $1.45.
Alcohol, Drugs and Brain Damage: Rankin, James G. (ed.) Addiction Research Foundation, Toronto, 1975, 101p.

Alcohol tops psychiatric admissions list

WASHINGTON, DC — Since 1969, when detailed statistics were first collected nationally by the National Institute of Mental Health, there has been little change in the three leading admission diagnoses in state and county mental hospitals — they are alcohol disorders, schizophrenia and depression.

Among male patients, between 1969 and 1973, alcohol disorders accounted for nearly 33% of admissions, followed by schizophrenia (26% to 30%) and personality disorders (7% to 9%).

In women patients, schizophrenia and depressive disorders accounted for 38% and 18% of admissions, respectively. However, by 1973, alcohol disorders had displaced organic brain syndromes as the third most frequent diagnosis among women — increasing from 8% to 13% of all female patients.

In both men and women, drug disorders have increased since 1969. They have, indeed, doubled — from 3.7% to 6.9% in men, and from 2.2% to 4% in women.
mental hospitals were also younger. In 1969, 39% were under 35 years of age; by 1973 this figure had gone up to 44%. However, those under 18 years of age had decreased in number — the rise was in the 18 to 34 age group. Most of the increase was among males, predominantly between 25 and 34 years.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

Interdisciplinary Conference on Conjoint Emergency Care — hosted by the Emergency Nurses Association of Ontario — Oct. 1-3, Toronto, Ont. Information: Ms. M. Victoria Eld, Apt. 5, 62 Old Mill Road, Etobicoke, Ont. M8X 1G7.

Symposium on Headache — Oct. 4, Toronto, Ont. Information: The Director, Office of Postgraduate Medical Education, University of Toronto, Toronto, Ont. M5S 1A8.

49th Annual Convention of the American School Health Association — Oct. 8-12, Denver, Colorado. Information: American School Health Association, ASHA National Office, Kent, Ohio 44240,

International Symposium on Alcoholism — Oct. 11-13, Porec, Yugoslavia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

First National Conference on Deliquency Prevention — Oct. 14-17, Niagara Falls, N.Y. Information: Mrs. Virtuoso, National Conference on Delinquency Prevention, Niagara Falls Convention Bureau, P.O. Box 786, Falls Street Station, Niagara Falls, N.Y. 14303.

Drugs, Alcohol and Women: A National Forum — Oct. 24-26, Miami Beach, Florida. Information: Muriel Nellis, National Research & Communications Associates, Suite 640, 1819 H St., N.W., Washington, D.C. 20006.

Alcohol Education and Primary Prevention — Oct. 27-28, Albany, N.Y. Information: Dr. Lois Stiglmeier, Coordinator of Prevention Education, Division of Alcoholism, N.Y.S. Department of Mental Hygiene, 44 Holland Ave., Albany, N.Y. 12229.

The Consequences of Alcohol and Drug Abuse During Pregnancy on the Mother and Her Offspring — Oct. 29, New York, N.Y. Information: Mr. D. Dougherty, Director, Public Relations and Community Information, Addiction Services Agency, 65 Worth St., New York, N.Y. 10013.

Fourth Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct. 31 — Nov. 1, Atlanta, Georgia. Information: Mr. J. Douglas, ALMACA, Suite 350, 300 Wendell Ct., Atlanta, Ga., 30336.

Third Annual Conference of the California Association of Alcoholic Recovery Homes — Oct. 31-Nov. 2, Asilomar, Calif. Information: Joe Collins, Executive Director, CAARH, P.O. Box 5396, Santa Monica, Ca. 90405.

33rd Annual Convention of the American Association of Marriage and Family Counselors — Inderdisciplinary Theme includes Addiction and Family Therapy, Nov. 7-9, Toronto, Ont. Information: AAMFC Office, 225 Yale Ave., Claremont, California, 91711.

Fourth Information and Feedback Conference — Nov. 12-13, Toronto, Ont. Information: IF Conference Committee, Counselling and Development Centre, York University, Toronto, Ont.

First National Conference on Occupational Alcoholism and Drug Abuse — Nov. 17-20, Ottawa, Ont. Jointly sponsored by Humber College and Addiction Research Foundation. Information: Jim Simon, ARF, West Toronto Branch, 4143 Dundas St. W., Toronto, Ont. M8X 1X2.

Symposium on Creative Sexuality — Study seminar of efficient and exciting use of sex counselling time with Drs. Noam and Beryl Chernick — Nov. 26-28, Toronto, Ont. Information: Creative Sexuality, Suite 400, 73 Richmond St., W., Toronto, Ont. M5H 2A1.

International Symposium on Alcohol and Drug Dependence — Nov. 29-Dec. 5, Bahrain, Arabian Gulf. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Second Caribbean Conference on Strategies of Drug Abuse in Developing Countries — Feb. 1976, San Juan, Puerto Rico. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Conference on Alcoholism and Drug Dependence — April 4-9, 1976, Liverpool, England. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Sixth International Institute on the Prevention and Treatment of Drug Dependence — June-July 1976, Hamburg, Germany. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

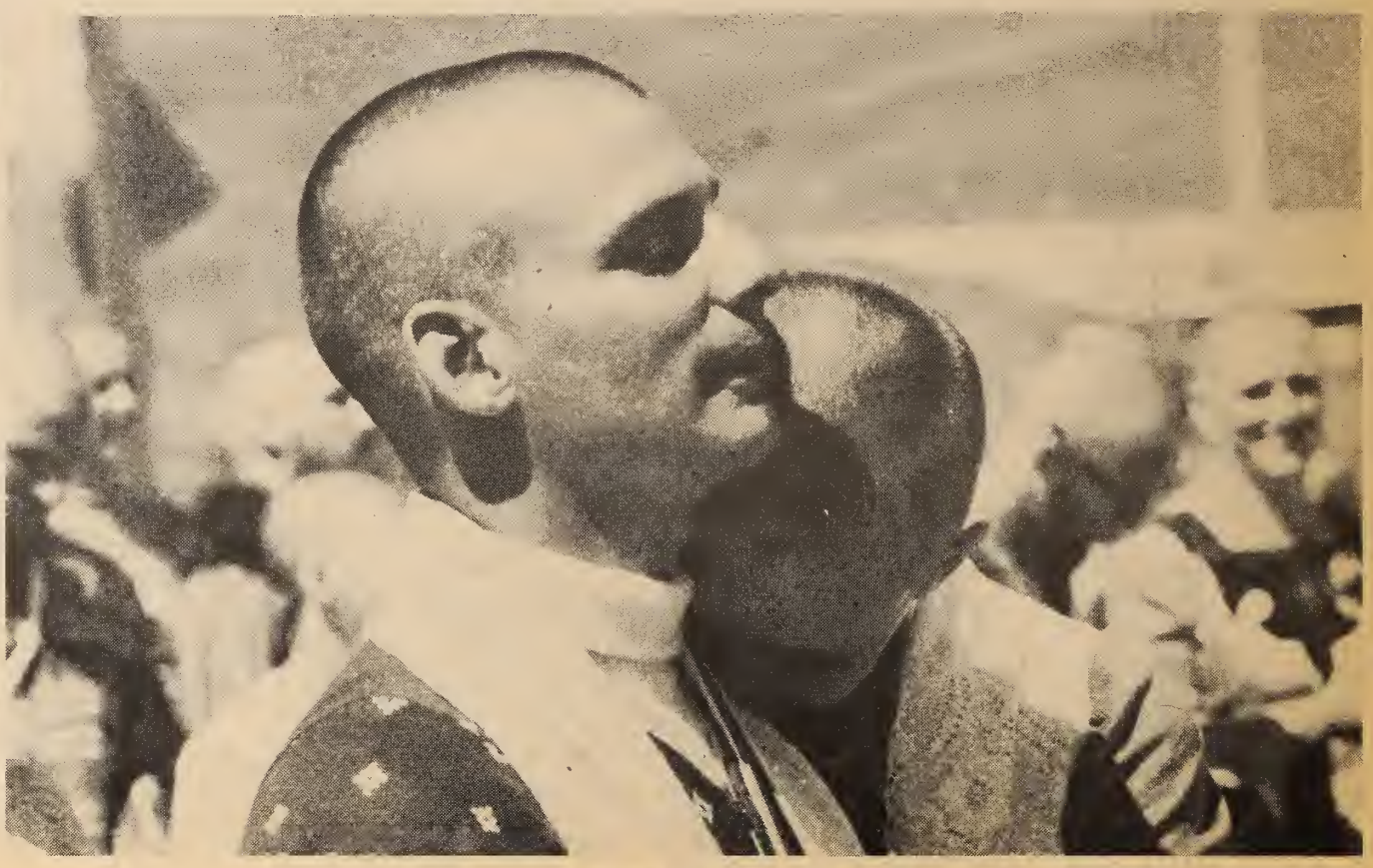
11th International Conference on Medical and Biological Engineering — Aug. 2-6, 1976, Ottawa, Ont. Information: Conference Office, National Research Council, Ottawa, Ont. K1A 0R6.

Seventh International Conference on Alcohol, Drugs and Traffic Safety — Jan. 23-28, 1977, Melbourne, Australia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Medical Symposium on Alcohol and Drug Dependence — Aug. 21-26, 1977, Tokyo and Kyoto, Japan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Synanon wedding festival 1975

"exellente drills and sweete songs"



IT WASN'T YOUR ordinary wedding.

But then nothing about Synanon, best known for its efforts to rehabilitate drug addicts, alcoholics, delinquents and other victims of "character disorders" could be considered ordinary.

With a current population of 1,350 located in facilities in Santa Monica, Oakland, San Francisco, the Sierra foothills, and a ranch in Marin County, Synanon was founded in 1958 by former alcoholic Charles "Chuck" Dederich who today is chairman of the board of directors (**The Journal**, January, 1975).

The Synanon Wedding Festival 1975 — probably the largest mass wedding ever held anywhere — brought together 101 couples in a tender and often moving ceremony at the 1,700 acre ranch in the rolling hills of Marin County, north of San Francisco.

Brides and grooms, dressed in exquisite home-made medieval costumes, were joined by more than 1,000 friends and relatives for the joyous occasion.

The couples had been married during the past year, usually with a civil ceremony.

This was their equivalent to a church wedding and in the tradition of Synanon life, they wanted to share the experience with their community, their friends and relatives.

The festival began with six minstrels singing the Synanon wedding song to the tune of Greensleeves.

Then, almost 200 members of Synanon's 'boot camp' (newcomer adults dressed in blue denim overalls and blue shirts) and Synanon's 'basic training' (newcomer juveniles) paraded across 'People's Park'.

To the accompaniment of a 15-piece resident band, a group of 'Synanon jumpers' demonstrated the community's aerobics program, compulsory daily cardio-pulmonary exercise for all Synanon residents.

A group of Synanon children — there are 290 under 18 years of age — danced a pavan to a single flutist.

Synanon elders, men and women associated with the community for many years, some since its inception, led the wedding march.

Then came the brides and grooms, walking hand-in-hand in a lengthy and colorful procession.

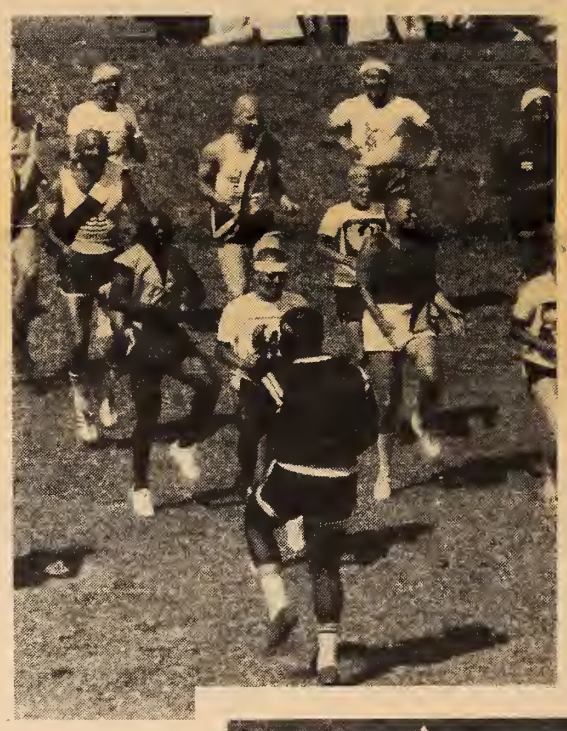
The Rev. C. Mason Harvey, a long-time Synanon resident, sustained the light mood with an entertaining and touching rendition of the marriage rites.

Tears welled in the eyes of many relatives who had flown from many parts of the United States to witness the spectacular.

The music echoed across the bowl of the sun drenched valley, as wedding couples danced under the clear blue California skies.

And then it was time for the huge feast prepared for 2,000. Tables creaked under the weight of Synanon fried chicken, corn-on-the-cob, melons, salads and pastries.

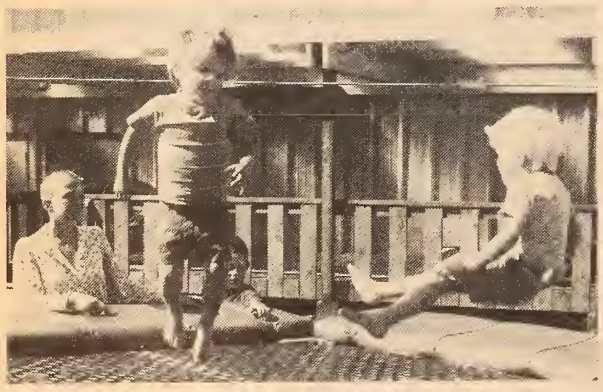
The merrymaking lasted into the night.



"Synanon — teaching and learning together.
The young, the old, the weak and strong, bound together by the Synanon Game.
Healthy bodies jumping up and down every day, smoke free and drug free.
Surely every day is the very first day of our lives."
— Master of Ceremonies, Synanon Wedding

THE BACK PAGE

Story and photos by Gary Seidler



"On February 26, 1975, 500 Synanon women shaved their heads, thus making a momentous decision to join with the organization's 800 men in a demonstration of commitment to its continuing work. The bald head in Synanon has always symbolized responsibility for the Synanon community, either in penitence for mistakes or in celebration of commitment.
Determined to become full partners in accomplishing Synanon's work, many women will remain shorn as a constant reminder of their dedication to their common cause."
— From 'A Bald Statement of Purpose' in the Synanon literature

SEE BACKGROUNDER PAGE 9

Year-old US army pot study surfaces

By MILAN KORCOK

A MAJOR study of the chronic use of marijuana, funded by the US Army and conducted by Dr Jack H. Mendelson of Harvard University, has been extracted from the military bureaucracy by the National Organization for Reform of Marijuana Laws (NORML).

Full report — The Back Page

The report, which cost the army $382,000, finds marijuana virtually benign in respect to any behavioral or biological risks of long-term use.

The abstract of the report lists these conclusions:

- No impairment in motivation to work for money even when users smoked a large number of marijuana cigarettes.
- Some decrease in work performance the day following heavy smoking, though "not biologically significant".
- Some impairment of lung function "closely related to the smoking process per se rather than to any pharmacological action of marijuana".
- No change in testosterone level. (Suppression of testosterone might impair sexual or procreative function.)
- Significant weight gain related to smoking marijuana.
- No evidence that chronic marijuana use impaired cognitive or neurological function.
- Some change in social and psychological factors associated with interpersonal responses, but not to the point of interfering with group behavior.

The report, which clearly substantiates many of the conclusions drawn in the Jamaica - Ganja study (**The Journal**, September) was discovered almost by accident when NORML filed requests with nine federal agencies for reports on any research being done on marijuana.

The request was filed under the Freedom of Information Act, designed to allow greater public access to data compiled with the aid of public funds.

The fact this report had been completed more than a year ago (September, 1974) and had not been publicly released, or even referred to during that period of time, prompted NORML's executive director Keith Stroup to charge the army with a "cover up" because it "didn't like what was found".

(See — US army — page 2)

The Journal

VOL. 4 NO. 11 PUBLISHED MONTHLY BY ADDICTION RESEARCH FOUNDATION TORONTO NOVEMBER 1, 1975

Federal government program

$13 million for Indians, Inuit

By ANNE MACLENNAN

OTTAWA — A multi-million dollar program to help native Indian and Eskimo people across Canada to combat the effects of alcohol abuse has been launched by the federal government.

The program is headed by E. D. (Ted) McRae, former executive director of the British Columbia Alcoholism Foundation, who was appointed in September.

Mr McRae was ousted from his BC position early this year when the new provincial government bought out his contract as part of its absorption of responsibility for alcohol and drug programs in that province.

Mr McRae told **The Journal** that by the end of March, 1976, the Native Alcohol Abuse Program (NAAP) expects to have made grants totalling about $1 million.

"And in the next two and a half years, or up to March 31st, 1978, the grants could total up to about $13 million."

He said the program would not be interested "in a helluva lot of forms".

"One of the things the program aims to do is exercise prudent controls but get them as simplistic as possible so programs are not stifled by bureaucratic structures. I hope we'll be able to achieve our objective.

"The proof of the pudding is going to be in the number of dollars that actually reach the people in the form of services."

Evaluation, he said, is going to be "a real administrative challenge . . . a real problem to reach sophisticated goals using unsophisticated methods.

"The trick is to develop meaningful measures which are simplistic. Jargon has no place in our program."

Grants given under the program are exclusively for about 17,560 Inuit (Eskimo) and about 276,440 Status Indians, i.e. those entitled to be registered as members of one of the 565 bands in Canada which have access to, or occupy, some 2,200 Reserves.

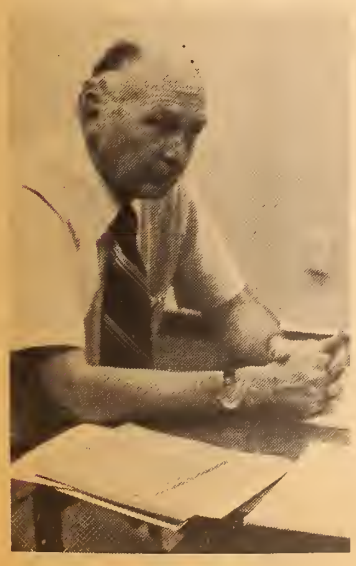
A spokesperson for the department of Indian affairs and northern development told **The Journal** that while the department has no official record, it is believed there are at least as many non-Status as Status Indians and possibly more.

Since June, when the program was beginning slowly to get under way, grants totalling some $621,128 have been made to groups in Alberta, Saskatchewan, Manitoba and Nova Scotia.

So far, said Mr McRae, there has been "a very satisfying response from the native people".

The new program is funded

(See — Government — page 2)



Ted McRae

Canada's economic squeeze delays pot bill

By BRYNE CARRUTHERS

OTTAWA — The price and wage controls and other economic measures introduced by the federal government will postpone once again the long-awaited legislation to ease penalties for marijuana and hashish crimes in Canada.

Mitchell Sharp, Privy Council president and the man who arranges the legislative timetable for the Commons, told **The Journal** that the cannabis legislation "is not at the top of my list" of bills to be dealt with this fall session, before Christmas.

Prior to the economic crackdown by Ottawa, Mr Sharp said the government had wanted to clear away the less than a dozen bills on the order paper from the summer sitting, with the intention of introducing new legislation only after this was accomplished.

The cannabis legislation, which has already successfully cleared the Senate (in a reversal of the normal flow of legislation, designed to help speed up the legislative backlog and also to allow the Senate to take a first, careful look at the judicial and social consequences of the cannabis bill changes), would have had a priority this fall.

Even with the priority accorded to economic legislation, however, the cannabis bill will not get lost altogether.

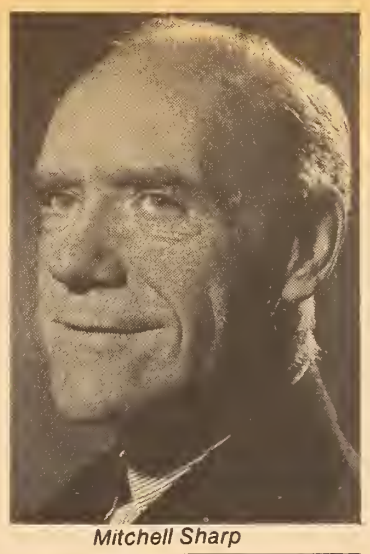
Mr Sharp said it is now likely the bill will be introduced along with a number of so-called 'peace and security" pieces of legislation dealing with crime, including proposed changes in paroles and pardons and possible modifications in gun legislation and abortion laws.

Proposals to stiffen the breathalyzer legislation would be another part of the legislative package.

The important question, according to Mr Sharp, is how long the parliamentary debate on the economic measures will drag on. If it's long, as many suspect, then much of the legislation on the order paper will be pushed into 1976, including the cannabis bill.

If this happens, Mr Sharp

(See — Cannabis — page 3)



Mitchell Sharp

On its way

US certification

By MILAN KORCOK

CHICAGO — The Alcohol and Drug Problems Association of North America (ADPA) has launched a national initiative to establish a certification process for drug and alcohol abuse treatment workers.

Announcing the action, association president H. Leonard Boche, told the ADPA annual meeting that the first step would be the convening of a meeting to include representatives of relevant national, state, and local organizations affected by the process.

Invitations were to be sent out by the end of October to groups representing the people to be certified, their prospective employers, and representatives of regulatory agencies.

Mr Boche emphasized that ADPA's action in initiating the process does not mean it intends to become the actual certification body, or even the permanent focus for activity in this field.

The ADPA is acting purely as a catalyst, said Boche, in response to what appears to be an "urgent need".

"No longer can we sit around

(See — Certification — page 6)

Women form caucus

By ANNE MACLENNAN

TORONTO — A women's caucus on alcohol and legal drugs has been formed in Ontario with the initial aim of following up on recommendations made at a special provincial consultation on women last month in Ottawa.

Some 23 recommendations focusing on upgrading services for women with alcohol and drug-related problems, and on refining the system which participants agreed had neglected such women, were drawn up at the intensive three-day Ottawa meeting.

The caucus, which met for the first time last week in Toronto and whose members were all participants in the Ottawa consultation, have refined the original 23 Ottawa recommendations down to 12 composite ones.

These 12 will be directed to a variety of federal and provincial government bodies, medical and nursing colleges and schools, professional bodies, and a wide range of other institutions and groups.

The full slate of recommendations will be sent to all the various bodies with a preamble stating what the provincial consultation was, how it came about, and what the concerns were.

A covering letter to each agency, institution, ministry or school will state which specific recommendation (or recommendations) is directed to them. The letter will also ask for an early reply in terms of what action is proposed as a result of the recommendation, and when.

The group expects to have at least a general idea of what

(See — Women's — page 5)

...INSIDE

Master plan developed

Native alcohol programming

By ANNE MACLENNAN

OTTAWA — The aim of the Native Alcohol Abuse Program may be to "keep things simple" as its chief says. But NAAP's origins and structure are anything but . . . at least at first glance.

NAAP is the culmination of several years of intermittent wrestling by various people and government bodies, with the increasingly obvious problems of alcoholism among Native Canadians.

Several years ago, according to E. D. (Ted) McRae, NAAP's executive director, the department of Indian affairs began to "plug money into native alcohol programs".

At the same time, the medical services branch of the department of national health and welfare began to fund some native programs. But it was "essentially ad hoc — there was no master plan", says Mr McRae.

Finally, about one year ago, the two departments gathered people from across Canada, concerned about native alcoholism, to discuss a comprehensive plan for the whole country.

The product, to make a long story short, and its official title, is the National Advisory Board on Native Alcohol Abuse which administers through Mr McRae, the Native Alcohol Abuse Program.

The national board is formed of two representatives each from the departments of Indian affairs and health (one from medical services branch and one from the Non-Medical Use of Drugs Directorate); and one each from the National Indian Brotherhood, the Inuit Tapirisat (Eskimo Brotherhood), and other national native organizations.

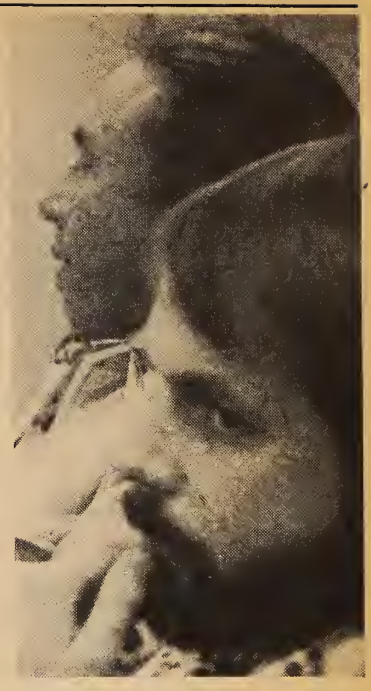
Under the national board are 12 regional advisory boards — one in each of the 10 provinces and two territories — usually established in centres where there are regional offices of the two departments.

These boards have one local representative each from Indian affairs, NMUD, medical services branch, the provincial alcohol or drug commission, and a maximum of three representatives from the local native community.

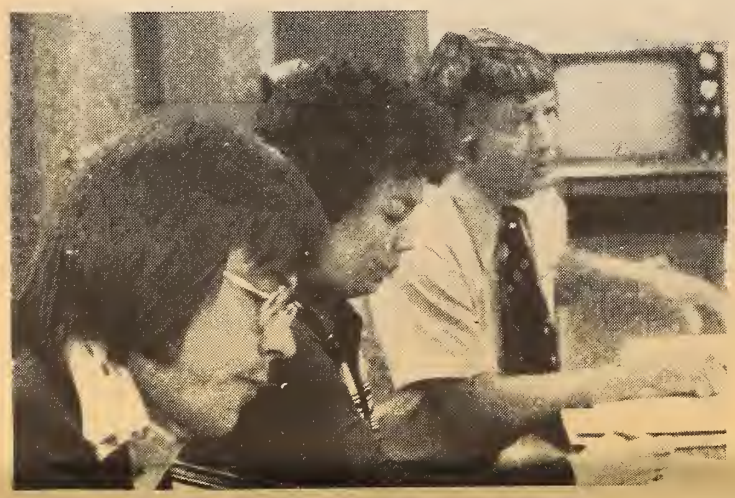
Consultants have been, or will be, appointed to each regional advisory board with the four Atlantic province boards sharing one consultant. They will provide advice to their boards on the extent and effects of alcholism; on methods to combat the problems; and on proposals submitted to the board by native groups.

Consultants already appointed are: Lawrence F. Paul, Atlantic region; Burton D. Kewatosh, Ontario; Eileen Pete, Saskatchewan; Eric W. H. Stamp, Alberta; Mac Nelson, British Columbia; and Bill Cline, Yukon Territory. Yet to be appointed are consultants for Quebec, Manitoba, and Northwest Territories.

Fifty per cent of the funds for the program are provided by medical services and 50% by Indian affairs but the total budget is controlled by the board.



Consultants Stamp and Nelson



Consultants Kewatosh, Pete and Paul

Government $$ for native needs

(Continued from page 1)

jointly by the medical services branch of the department of national health and welfare and the department of Indian affairs and northern development.

The ultimate goal, said Mr McRae, is a "comprehensive program covering prevention, treatment, and rehabilitation and involving maximum participation by the native people".

The more immediate goal is "to test and evaluate a variety of approaches" to the alcohol problem in order to establish a firm base for the program which is set up for a three-year period only.

"One major objective is to encourage and assist the native people themselves to develop programs to meet their own needs and indeed manage them.

"We hope we can develop some innovative approaches that may be particularly for native people."

He termed alcohol abuse "probably the number one health problem faced by the native people which accounts for their inordinately high death rate — by accidents, shootings, drownings for example".

However, "so much talk about drunken Indians has become kind of old hat".

The important thing now, he said, is "the people themselves have become aware of their problems and are striving in a very positive way to do something about them.

Initial enquiries by interested groups should be directed to the Regional Director, Indian affairs and northern development, or to the medical services branch of the department of health.

Mr McRae said: "In ordinary terms, our funding might look very liberal.

"For example, 300 people may get $50,000 per year for a program. On a per capita basis, this is much higher than provinces would likely appropriate for non-native people."

He said this was largely because of "peculiar problems of geography".

Settlements are usually isolated from each other and from services provided by provincial commissions.

NORML leads cannabis reform effort

By DAVID MILNE

SAN FRANCISCO — Cannabis crusaders in North America are intensifying their efforts to reform marijuana laws.

The most recent development is a suit to be filed next month by the California branch of NORML challenging the constituionality of the state law prohibiting private, non-commercial use of marijuana. (NORML is the National Organization for the Reform of Marijuana Laws.)

"What we are seeking to accomplish ultimately is a declaration by the California State Supreme Court that individuals have the right to grow, possess and use small amounts of marijuana in their homes," NORML's west coast coordinator Gordon Brownell told **The Journal**.

The suit is modelled after the landmark Rabin decision handed down by Alaska's Supreme Court in May deciding in favor of one's right to privacy, hence right to use marijuana, in one's own home.

The California suit will be bolstered by a right to privacy clause that was added to the state constitution in 1972.

"We are going a step further than Senator Moscone's bill," Mr. Brownell said.

The Moscone bill, which becomes law next year, reduces the penalty for possession of one ounce of the drug to a misdemeanor subject to a maximum $100 traffic ticket-type citation.

"We are challenging the whole concept of laws that prohibit private use and possession of marijuana," says Brownell, "And by filing suit next month we will be filing before Senator Moscone's bill takes effect."

However, he emphasized, the suit would in no way challenge the Moscone bill which would remain in effect in terms of public use and possession.

An individual using marijuana in public would still be subject to a citation and a fine for public use, whereas in private the person would not be subject to harassment and criminalization.

The suit will not cover minors or the sale of marijuana in private, he explained.

"But basically the state does not have a compelling interest in regulating private marijuana behavior as long as no one else is being hurt or affected," he added.

NORML has similar suits going in other jurisdictions including the US Federal Courts and courts in Illinois, Louisiana and several other states.

Since 1973 decriminalization bills have passed in Oregon, Ohio, Alaska, Colorado, Maine and California.

Next year an estimated 25 other states will consider marijuana reform bills, and NORML is hopeful of success in New York, Massachusetts, Michigan, Minnesota, New Jersey and Pennsylvania.

By December, marijuana reform may be on the floor of the Senate as an amendment to the new comprehensive federal crime code.

For the California suit, Brownell says: "We will assemble the finest of medical and legal experts in the country."

He also indicated a change of focus in future campaigns.

"We in California feel that the legislature has gone about as far as it will go for the next couple of years, so we are changing the forum of our reform activity from the legislature to the courts for the next year and a half."

And with good reason: US courts have been expanding their interpretation of the "right to privacy" in other areas, such as birth control and pornography.

"So we think it is time the courts addressed themselves to the issue of privacy as it pertains to marijuana use.

"If the suit is successful it will get the law and the police out of people's homes and backyards when it comes to possessing, growing or using small amounts of marijuana for personal use."

Boudreau wins international Browning Award

DR ANDRE Boudreau, former director of the Office for the Prevention of Alcoholism and Other Toxicomanies (OPTAT) has been awarded the international Edward Browning Award to recognize his work in the field for the past 20 years.

Dr Boudreau, the 1975 winner, is the first Canadian recipient of the award which has been presented annually since 1971 by the International Council of Alcohol and Addictions.

This has been a momentous year for Dr Boudreau. In early summer, OPTAT was virtually phased out of existence (**The Journal**, June) and Dr Boudreau was appointed special councillor in the fields of alcoholism and drug addiction to Quebec Justice Minister Jerome Choquette.

He also chairs the provincial government committee on alcohol and other drug advertising.

Unquestionably, Dr Boudreau still wields considerable influence and he assured **The Journal** earlier this year that influence will be used to maintain and foster good interprovincial and international relations in the specialized areas of alcohol and drug dependencies.

US army pot study surfaces

(Continued from page 1)

"This is very important information and should have been disseminated. The work was paid for with tax dollars and the public should be told these findings immediately," said Stroup.

In fact, some of the results have been emerging via the scientific journal process. Dr Mendelson's work on testosterone, funded by the army, has been reported. So has information involving comparative pharmacology of alcohol and marijuana, and relationships between marijuana use and motivation.

In response to NORML's charges, Col. France F. Jordan, executive officer of the Army Medical Research and Development Center which commissioned the study, said these studies do get into the medical journals but "everybody's too damned lazy to pick them up".

Stroup contends release of this data under one cover, in comprehensive form, might have made considerable public impact at a time when the marijuana debate was quite fervent.

Stroup, however, admits the army was "fairly responsive" to the NORML request, much more so than any other federal agencies, one of which reportedly requested a $300 fee to make a computer search of what was available.

In response to NORML's request, the army first sent summary sheets describing four different research projects being done.

"All we got back were one-page summaries," Stroup told **The Journal**. "But when we saw this one, a bell rang."

NORML subsequently filed a request to get the full report, but Stroup, who admits he was impatient with what he felt was a "runaround", released copies of the summary to *The New York Times* and the *Washington Star*.

"We needed help so let a couple of journalists have the summary."

Within one week after news of the summaries appeared in the press (Oct. 4 and 5), full copies of the report were given to NORML.

The Journal's request for the report was filled immediately.

Driver education courses — 'trendy' but not THE answer

By JOY-ANN COHEN

LONDON, ONT. — Convicted impaired drivers are getting what's "in" and not what is indicated, says a University of Western Ontario sociologist.

What's "in", says Paul Whitehead, also an Addiction Research Foundation of Ontario consultant, are Phoenix or Edmonton model programs in which drivers take one-night-weekly courses for four to six weeks.

(The first education program for impaired drivers was in Phoenix, Arizona. Canada's first, in Edmonton, was based on that model.)

Participants are "shown films, lectured to, made to answer questionnaires, and given the opportunity to undergo counselling," Dr Whitehead told the annual meeting in Quebec City of the Canadian Foundation on Alcoholism and Drug Dependencies.

He labelled the courses "politically safe, high profile programs that tend to provide a false sense that sweeping action is being taken against impaired driving".

Referring to a 1972 study showing that one of 2,000 drinking and driving incidents results in an arrest, he said only those convicted after arrests are exposed to the programs.

Even if Phoenix type programs are successful, "only one eightieth of one per cent of actual instances of impaired driving have been prevented".

What is needed, he said, is a program that will deter a large number of people from driving while impaired.

He suggested lowering the legal limit of blood alcohol concentration (BAC) from .08 parts per million to .04. If the legal maximum BAC tends to become the norm, as has been shown, .08 is too high to prevent traffic fatalities caused by drunken drivers, he said.

He would also like to see large-scale roadside prescreening by simple, inexpensive techniques, with later verification of positive cases at police headquarters.

Meanwhile, he wants publicity for the program, so fear of and chance of arrest will be so high people will no longer drive after drinking.

The popularity of the Phoenix courses, Dr Whitehead said, results from "our belief in education as a cure-all and our distorted picture of who actually drinks and drives".

The typical person in a "Phoenix" program is a 37-year-old working-class male but these people are not representative of drinking drivers, he said.

That is because allocation of police monitors is on the basis of total police activity in any area and working-class men are more likely to be where the breathalyzers are — in a city's downtown area where they live and entertain themselves, he said.

Middle-class drinker-drivers living in the suburbs and attending private parties, pass few police patrols, so they are not often caught, Dr Whitehead said.

"In this sense, the 'typical' drunk driver is simply a victim of his style of life and residential patterns."

Thus, people sent to the educational programs have average or below average levels of education. "So education is seen as a 'good thing' for them . . . . There is a sense in which he (the student) is 'the other guy,' unlike us, who needs to be processed in some way because he does not behave as we feel he should."

The programs have little impact on the total incidence of impaired driving because only the "tip of the driving-while-impaired iceberg" ever attends.

Paul Whitehead

And about 30% of those who are caught are alcoholics or others with serious drinking problems, who may be impervious to the educational approach.

Dr Whitehead allowed that the programs may be useful in identifying alcoholics early and helping them in other ways.

In suggesting new breath laws, Whitehead criticized those in existence, saying their temporary effectiveness was due to publicity, not better techniques. When drivers realized their actual chances of getting caught had increased little, despite the publicity, they reverted to old drinking habits.

Young people — "today's niggers"

By DAVID WOODS

NIAGARA FALLS, NY — We wear our hair like they do, we dress like they do, but we don't *like* kids in this society says the director of prevention, National Institute on Alcohol Abuse and Alcoholism (NIAAA).

In fact, Donald G Phelps told the First National Conference on Delinquency Prevention here, young people are "today's niggers": They have no united voice, no power base. Mr Phelps is Black.

In a panel discussion on community mobilization to prevent alcohol problems in youth, Mr Phelps urged workers at the local level to "put the heat on" funding authorities, to write to their state governor or congressman; but in any event, to understand *the system.*

"It bothers me", he said, that NIAAA is funding organizations fighting other social ills as well as alcoholism, and using a large percentage of our prevention budget for that purpose.

Donald Phelps

"We have a $3.5 million clearinghouse . . . . but we gave the National Council on Alcoholism $1.5 million to do the same damn thing . . . and I think that if we were to take that money and spread it out among the programs (represented) in this room it would have more of an impact than it's having."

On the subject of the effect on drinking patterns of lowering the legal drinking age, Phelps was unequivocal, even seeming to regard this as a non-issue.

In societies where young people are introduced to alcohol at an early age, he said, there is frequently no problem; in our society, a 15-year-old might handle alcohol well, and a 40-year-old may be quite immature about it.

The important thing, he said, "is to get away from the ignorance and ambivalence surrounding the use of alcohol in the community".

An example of this, he said, particularly as the major influence on young peoples' drinking patterns is the home, is the father who drinks and then drives — and tells his children they should never do the same thing.

This Niagara Falls conference, at least, showed no such ambivalence: In deference to the approximately 100 youth representatives among the more than 1,000 US delegates, no liquor was served at any social functions.

Teaching by example may in fact be one way of coming to grips with alcohol problems among youth.

Judith Katz, chief of the NIAAA's Youth Education Branch, described a program in Philadelphia, "but it could have been anywhere", in which college students work with high school students, and high school students work with those from junior high.

The three-member groups work as a team, she said, meeting after school each day to help each other academically as well as having "non-structured rap sessions" to deal with current living problems. What this exercise is about, said Ms Katz, is the acquisition of life skills and development of community awareness, as behavior — including drinking behavior — stems from personality and environment, and young people need to feel good about both.

Donald Phelps added that all students in the Philadelphia program were identified as "high (school dropout) risk . . . highly verbal leaders, or troublemakers — you use your own term".

But all of the high schoolers involved, he said, have gone on to complete their courses and enter college. The program is now in its third year of NIAAA funding.

As Judith Katz pointed out, over 70% of US high school students drink alcohol and, as there is little hope of preventing that, the approach should be to reassure those who don't that that's okay and teach those who do drink responsibly — using example and peer involvement — and to try to circumvent the problems associated with alcohol abuse.

There are other approaches. Panellist Myles Doherty, senior program advisor to the US Office of Education's division of drug education, described one in which multi-disciplinary teams of specifically-trained professionals received federal funding to provide three-week intervention programs on alcohol and drug abuse in the high schools. Joseph Dolan, director of the US Jaycees' Operation Threshold project, spoke about that organization's activities with youth and alcohol.

Cannabis bill

(continued from page 1)

said the fall session would not end before Christmas but would likely be continued after the Christmas-New Year break until all the legislation is passed. In other words, there would not be the standard Throne Speech when MPs return to Ottawa in January.

This is important, because unless and until the legislation is passed before the Throne Speech, all of the debate and procedure on bills not passed is lost and the government would have to start from the beginning (first reading) again.

So, even if the economic legislation dominates, it would seem the cannabis legislation will finally be approved and made the law of the land after three years of promises by the Liberal government.

As for the other side of the economic war being waged by Ottawa, that is the spending and hiring restraint within the federal government bureaucracy, it is still uncertain what its impact will be on existing and planned future programs.

Federal health department officials in the drug and alcohol field are assuming they will not be able to get more money next year than they have now. Nor will they be able to expand staff.

This, then, could put back the squeeze on Ottawa's much-talked about plan to attack the alcoholism problem in Canada more vigorously. It could also force the provinces to take up the slack (assuming they themselves have extra resources available).

Of more concern is the possibility a frozen federal budget could result in existing programs being cut back in order to meet growing financial needs of other programs deemed more important by government or of programs that involve statutory payments (such as pensions and Unemployment Insurance and Medicare).

Federal health officials admit that drug abuse and alcohol programs have slipped in terms of priority within the government, as public and political interest in drug problems has faded.

About the only thing that can be said so far is that no one really knows what will happen as yet, although there does seem to be more resolve on the part of the government this time than ever before, to restrain spending and hiring.

UK controls backfire

By ALAN MASSAM

LONDON — The myth that British control methods have contained the drug abuse problem has finally been exploded — at least in the capital.

As noted by field workers, there has been a very significant increase in misuse of barbiturates since the prescribing of heroin was restricted to government-controlled hospital drug clinics in 1968.

This is confirmed by a study published by the Accident and Emergency Department of London's famous Middlesex Hospital.

It reveals that an eight-year register of drug users seen in the department shows an alarming trend towards barbiturate abuse, often in combination with other drugs.

The hospital, situated just north of the Soho night-life district where young drop-outs tend to congregate, concludes that "the number of young people between 16 and 25 appearing in casualty departments suffering from the side effects of multi-drug abuse is becoming a cause for concern."

The report's authors, two senior nursing officers, Bill Mitchell and Beryl Rose, say: "If some control is not initiated over the use of polydrugs, with special reference to the dangerous level of barbiturate abuse, then we might be seeing the beginnings of an even more serious drug abuse problem in this country."

The report records an eight-fold increase in the number of incidents involving patients suffering with drug abuse complications brought to the hospital over the period studied (from a total of 110 in 1968 to a total of 496 in the period January-July 1975).

The Middlesex Hospital study has been backed by some parallel research from the Institute of Psychiatry's Addiction Research Unit (The Maudsley Hospital).

The unit carried out a survey of patients seeking attention for drug overdosage in the casualty departments of more than 60 London hospitals over a two month period.

It suggests that more than 1,500 Londoners attend hospitals every month either with drug side effects or to get drugs to satisfy their addiction. By far the greatest proportion of attendances were connected with barbiturate abuse.

Canadian statistics

Smoking stays at 'epidemic' level

By BRYNE CARRUTHERS

OTTAWA — If the success or lack of success of the government campaign to stop smoking is any indication, government anti-drug and specifically anti-drinking campaigns can be expected to have only marginal impact.

Not long ago federal legislators believed that putting dire warnings on cigarette packages would convince Canadians their health was more important than smoking. And for a while it looked as though the warning and the sophisticated anti-smoking advertisements might be working.

But the latest statistics from the federal Non-Medical Use of Drugs Directorate here indicate smoking remains at epidemic proportions.

For 1973, the last year statistics on Canadians' smoking habits are available, there were an estimated 6,341,000 regular cigarette smokers 15 years old and older, or 191,000 more than in 1972. In previous years, there had been a slight decline in smokers.

But in 1973, the trends towards a larger proportion of non-smokers and an increasing number of women smokers seem to have levelled off, with the prospects of a return to a steady increase in smokers in future years.

Only two of five Canadians 15 years of age and over are habitual smokers, according to the statistics.

Yet, according to different statistics, this time the estimated per capita consumption of cigarettes by Canadians 15 years of age and older, the drop in cigarette consumption lasted only three or four years, between 1967 and 1970. Since then, the consumption trend has returned to a steady climb upward.

These statistics show that in 1974, enough manufactured cigarettes were consumed so that every man, woman and child in the country could have puffed on 2,545 — seven a day for each and every Canadian.

If one restricts the per capita calculation to persons over 15 years, then in 1974 the per capita consumption of manufactured cigarettes was 3.494, or 9.5 cigarettes per person per day.

Of course, these figures do not include consumption of hand-rolled cigarettes (which could become more popular these days of inflation).

Total consumption of manufactured and hand-rolled cigarettes in 1974 amounted to 63.8-billion. On a per capita basis, that amounts to 2843.6 cigarettes per Canadian or almost eight cigarettes per person per day.

At three cents a cigarette that's almost $2-billion dollars a year that Canadians spend on cigarettes.

Just for comparison, in 1920 some 285 manufactured cigarettes were consumed in Canada per capita. By 1964, the number had jumped to 2,107. And by 1974, per capita consumption had increased another 20% (despite a dip in the late 1960s) to 2,545 — 800% higher than in 1920.

The 1973 data on the smoking habits of Canadians (as distinct from statistics on cigarette consumption) signal the end of the trend set between 1965 and 1972, when there was a steady increase in the percentage of non-smokers and when a large number of male smokers and, to a lesser extent, women smokers succeeded in kicking the habit.

In a slight turn-around, the 1973 statistics reveal a slight decrease in the percentages of both male and female non-smokers. The government experts are not sure how significant the difference is between 1972 and 1973.

But, it is obvious the percentage of non-smokers is levelling off to approximately 53% of the Canadian population 15 years of age and older.

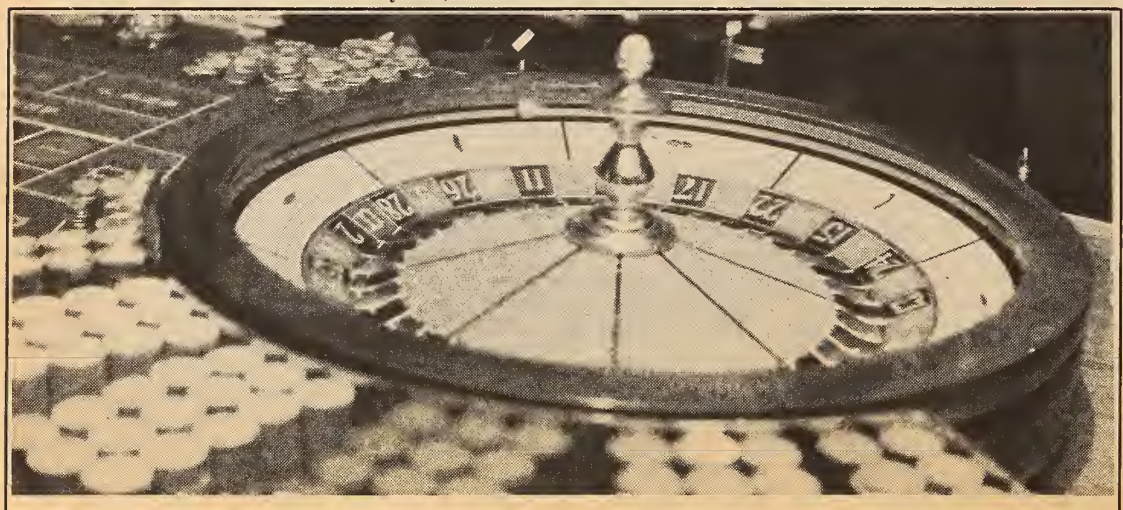
"The proportion of regular cigarette smokers among adult Canadian males and females also appears to have stabilized, although slight increases between 1972 and 1973 were found among males 20 years and over, and among females 20 to 24, 45 to 64, and 65 years and over," the report says.

Regular smoking among teenage boys also seems to be levelling off, which is one of the few good signs.

And the trend of a substantial increase of regular smoking among teenage girls between 1966 and 1972 also seems to be levelling off.

By region, Quebec continued to lead the nation in 1973 as the province with the heaviest smoking pattern for both males and females and with the lowest proportion of non-smokers.

British Columbia had the highest proportion of male non-smokers 15 years of age and over, while Ontario continued to have the highest proportion of female non-smokers.



"A masochistic wish to lose"

Gamblers, addicts share needs

By MARY HAGER

SAN FRANCISCO, CAL. — Gambling, like alcoholism and other forms of substance abuse, is an addictive disorder, a Harvard Medical School researcher believes.

Likewise, Louisa P. Howe believes, addiction is a form of gambling.

She told the recent American Sociological Association meeting here that a study of gambling might aid in understanding substance addictions and an understanding of the gambling aspects of addiction might aid in treatment.

The United States has an estimated six million compulsive gamblers, compared with the estimated nine million alcoholics and one million heroin addicts, said Ms Howe.

These gamblers experience a mysterious thrill closely akin to a "high" as they "wait" to see what fate has in store," she said.

The compulsive gambler's efforts to control his gambling can also produce such "withdrawal symptoms" as stomach pain, palpitations, muscle cramps, insomnia, nervousness and irritability, she added.

"The craving to gamble can become as overwhelmingly intense as any craving for drugs or alcohol," she said. "It is just as difficult to control and just as hard to keep under control."

Clearly no substance is involved with gambling and "it would seem nonsensical to say a person is physically addicted to, or dependent on, gambling".

This very difference, however, is what makes gambling a prototype of addiction: It demonstrates the powerful addictive influences within people "without the blurring and distraction" that occur when a substance is involved, said Ms Howe.

She suggested the choice of addiction — be it gambling or substance misuse — depends largely on "the social-recreational opportunities and role models available".

Ethnic identity may also play a role, she said, noting that Irish-Americans, for instance, often turn to alcohol but rarely to gambling, while Jewish people tend to avoid alcohol but are susceptible to compulsive gambling.

An alcoholic or gambling parent and various family traits frequently identified with other forms of addiction — an authoritarian, distant or missing father, and a mother who stimulated dependency — all seem involved in the development of the compulsive gambler, she said.

Ms Howe suggested gamblers and addicts also share an "inexorable, though unconscious, wish to lose . . . a manifestation of what has been called psychic masochism".

Looking at addiction as a type of gambling, she said

addicts "tend to be losers long before they become addicted to any drug". The experience of losing is seen as a moral injustice and someone else, some "fate" or "society", is always to blame.

The first and most crucial gamble an addict takes is to "dabble" with drugs, as an addict never consciously intends to become addicted and is always sure "he will win in the game of experimentally playing with drugs", she said.

Once addicted, however, the illegality of drug use, the ever-present dangers of arrest, of infection, of death from an overdose or while obtaining drugs, all "add to the charm" and intensify the gamble, she said.

"Thus any kind of addiction can be seen as essentially a game of Russian roulette."

Implicit within the analysis are implications for treatment: Ms Howe believes therapists must understand the addict's wish to lose and to be "passively overwhelmed".

Such efforts as giving support, providing employment, or training to people who feel they have been "unjustly deprived," are often doomed to failure. The addict gets "masochostic pleasure" out of losing.

...The human cost

By THOMAS LAND

GENEVA — The worldwide increase in cancer mortality in countries where cigarette smoking is widespread, continues without interruption.

In women, whose cigarette consumption has been rising rapidly over the past 30 years, lung cancer mortality continues to rise at an increasing rate.

This is some of the disturbing statistical evidence on the human cost of nicotine addiction worldwide, published by the United Nations' World Health Organization (WHO) in Geneva.

A digest of the document (WHO Technical Report Series No. 568, Report of a WHO Expert Committee) makes the following points:

- **The reduction in the risk of lung cancer in smokers of filter-tipped cigarettes with relatively low tar delivery compared with those who continue to smoke plain cigarettes has been confirmed.**
- **The mortality of Japanese cigarette smokers, both male and female, is some 22% higher than that of non-smokers. The risk increases with increasing cigarette consumption and with inhalation of smoke.**
- The striking reduction of lung cancer mortality in British physicians, the majority of whom are non-smokers or have stopped smoking, has been documented.
- **Research evidence published over the past few years strengthens the view previously advanced with reservation, that cigarette smoking is a major risk factor for both fatal and non-fatal myocardial infraction.**
- **Carbonmonoxide plays an important part in the mechanisms whereby smoking increases ischaemic heart disease. The amount of carbonmonoxide produced increases towards the end of the cigarette.**
- **In young people, ischaemic disease of the legs (thromboangiitis obliternas), causing intermittent claudication, appears to be confirmed almost exclusively to those who smoke.**
- **Several recent studies carried out in various countries have confirmed that the incidence of gastroduodenal ulcer is about twice as high in smokers as in non-smokers.**
- **The main effects of maternal smoking are to retard fetal growth and increase the risk of perinatal death; but there is some evidence that children of mothers who smoked during pregnancy may still be slightly smaller and show slightly lower levels of achievement by the time that they reach seven years of age.**
- **Several studies have shown that the children of parents who smoke are more liable to chest illnesses than the children of non-smokers.**
- **The non-smoker exposed to the side-stream and mainstream smoke of smokers in enclosed and ill-ventillated spaces, such as cars and small offices, may be exposed to harmful concentrations of smoke.**
- **In some communities, the traditional way of smoking tobacco by bubbling the smoke through a pot of water may be less damaging than cigarette smoking. On the other hand, some other ways of using tobacco — such as chewing — may produce other manifestations, such as cancer of the oral cavity.**
- **Pipe and cigar smokers, who do not usually inhale, are exposed to lower health risks than cigarette smokers who usually inhale.**
- **In certain developed countries, the publication of scientific findings on the effects of smoking seems to have reduced cigarette consumption to some extent. But consumption in developing countries is rapidly increasing.**
- **Most countries have not as yet taken any legislative measures to reduce smoking, while others have taken measures related only to cigarette advertising. WHO has studied legal arrangements in 100 countries, 70 of which have taken no steps whatever aimed at controlling the promotion or use of cigarettes.**

Patricia Badiet

Review of alcohol, drug literature shows

Researchers have ignored women

By ANNE MACLENNAN

OTTAWA — Women will continue to use and misuse drugs in ever-increasing numbers unless there is a drastic change in society's attitudes to them.

This is the chief conclusion of a 58-page analysis of the literature on women, alcohol and other legal drugs by Patricia Badiet, an Ottawa social worker.

"The most striking result of my review of the literature was to discover the point to which the nature of women's oppressive role has remained unacknowledged by the majority of researchers and providers of services.

"They would all appear to have ignored the possibility that women could be finding their position in society to be more frustrating and less rewarding than men do."

Ms Badiet's review formed part of the requirements for her master's thesis at Carleton University's School of Social Work this year and was the catalyst for the consultation.

She is particularly critical in her paper, of the dearth of attention to the area of women and alcohol.

She says her nine-month review "clearly indicates that alcoholism among women is a more serious problem than current statistics reveal and . . . despite growing evidence of the severity of the problem of alcoholism as it affects women, their needs continue to be ignored."

She refers to one study which found that between 1928 and 1970 "only 28 studies on women alcoholics were published in the English language as compared to the thousands on male alcoholics".

"Because of women's traditional role in society, their alcoholism has been covered by husbands, doctors, families, courts, police etc.

"The greater stigma for women has handicapped referral for treatment and caused them to be labelled 'sicker' than their male counterparts."

Ms Badiet says the special stigma attached to women who misuse alcohol has been acknowledged by a number of researchers and "the reason would appear to be the strategic place they hold in the family as wife and mother".

"It is easier for a husband to decide that his wife is mentally ill and send her to a psychiatrist or hospital than to decide she is an 'inebriate' and send her for treatment for alcoholism."

The fact that women often share the wider society's attitude only exacerbates the situation.

"They share society's opinion of them and are likely to suffer more self-loathing and self-contempt than men do. This severe ego-devaluation might make it more difficult for women to recover. It might also explain why there is more suicide with these women."

As for use of legal drugs, Ms Badiet says; "Just as female alcohol abusers are not showing up statistically . . . so it would seem that many women are using or abusing drugs without being reported or showing up in treatment programs.

"Women take fewer illegal drugs than men do but they are distinctly over-represented in prescription drug use. They take more tranquillizers, antidepressants, strong sedatives, dangerous diet pills and powerful analgesics.

"Men who abuse these drugs obtain them over the counter or illegally. Women tend to use and misuse such legal drugs by prescription from a family physician."

Her review confirms that women have received greatest attention mainly where there is concern about their effect on others, i.e. husbands, children, doctors, and that the research on women and comparisons with men "abound with myths, sexism, patriarchal notions and double standards".

It also indicates that not only has referral for treatment been more difficult because of society's attitudes but also treatment programs have been designed for men "with little attention to the special needs of women".

In medical education

Myths, shibboleths 'endemic'

OTTAWA — To understand why two times more women than men take psychotropic drugs, it is crucial to understand the expansion of the medical model to include "problems of living", says a Canadian sociologist-scientist.

The spillover of social problems to the medical model, together with the development of psychotropic drugs, has had a "profound effect on the medical profession", according to Ruth Cooperstock of the Addiction Research Foundation of Ontario.

Particularly important has been the "sanctioning within a medical model of a variety of stereotypic views of women, as well as the provision of the 'tools' with which to treat the 'problems' seen".

As an antidote, she says, it would be "a valuable start to demand the deletion of all drawings or photographs of men or women from advertisements by the pharmaceutical industry".

In addition, she suggests greater emphasis should be placed on the study of behavioral sciences by medical students and others providing services.

This would help them to recognize social stereotypes and the role of their own values as they effect judgements of problems and treatment methods, and also to understand the limitations of traditional medicine and the value of other, alternate services.

In a working paper prepared for the consultation, Ms Cooperstock says: "Women clearly do report more feelings of discomfort, more symptoms than do men.

"They also engage in more active intervention in helping to alleviate these symptoms whether that takes the form of attending a physician or of self-medication."

The fact they exceed men in their consumption of psychotropics, in a reasonably constant ratio over time and place of two to one, "suggests a certain immutability".

"However, a socio-cultural approach to this problem rejects the concept of immutability . . . unless one also accepts the immutability of the social structure of society."

Use of psychotropics, she says, is the product of a particular relationship — the patient to his/her doctor — and "myths and shibboleths regarding females still seem endemic in most medical education".

"The first point to establish is that, as of 1975, 92% of Canadians physicians are male."

Their attitudes, she says, have been determined "by early experience, by medical education (and the proportion of female teachers in medial schools is lower than that in practice), by continuing contact with peers, continuing education courses, ever-present detail men, pharmaceutical advertisements, and not least, by the patients with whom they interact on a daily basis".

Referring to a study in Scotland of attitudes towards and perceptions of male and female patients among general practitioners, she says physicians made clear distinctions between sexes and it was the miscellaneous category of vague, poorly defined symptoms that most differentiated the physicians' views of their male and female patients.

Sleeplessness, general feelings of unhappiness, headache and fatigue were dramatically more frequently perceived among women. "Even financial difficulties were seen as a common female issue.

"If financial difficulties, loneliness, disobedience of children are commonly seen as problems presented to physicians, then we must hardly be surprised by the increase in psychotropic drug consumption that has taken place in the past decade.

"These problems of living have somehow become 'medical problems' by definition, if only because they come up in the physician's office.

"We have reached the chicken and egg dilemma and can ask the question: Would so many social, personal problems be defined as medical problems today if psychotropics drugs did not exist or, conversely, would psychotropic drugs have proliferated as they have if the pharmaceutical industry had not helped to 'medicalize' living?"

Ruth Cooperstock

ANNE MACLENNAN reports from a provincial consultation on women, alcohol and other legal drugs

Psychotropic use— why worry?

OTTAWA — Why the concern with increased use of psychotropics? It's a legitimate question, says Ruth Cooperstock.

Clearly, reliance on psychotropics for individual solutions to problems of living is a value-laden position, she says.

"It is consistent, however, in its opposition to large scale use of these drugs, with a segment of concerned medical opinion who see physical problems as consequences of use."

She quotes the author of an article in a recent issue of the British Medical Journal:

'Most of the psychotropic drugs in common use have some well-known side effects.

'Barbiturates cause dependence and depression; . . . . tricyclic antidepressants may produce unacceptable atropine-like side effects and cardiac arrhythmia . . .; the benzodiazepines appear relatively non-toxic but also may produce "hangover" and dependence.

'The latest worry is the possibility of interaction between drugs being used simultaneously . . . . Most psychotropic drugs interfere with the rate at which other drugs are metabolized, and this may lead either to prolonging or reducing the effect of other drugs in use at the same time . . . . Very few doctors either in hospital or general practice carry the knowledge of pharmacology necessary to predict safe and unsafe combinations.'

Women's caucus to follow up recommendations

Lavada Pinder, ARF Eastern Ontario region, and a chief organizer of the Ottawa consultation.

(continued from page 1)

kind of reception the recommendations are having by the end of January.

Ruth Cooperstock, a member of the caucus and an ARF scientist-sociologist told The Journal the outcome of the first wave of material is likely to be "very varied".

One of the recommendations, for example, is that a federal computerized registry of all prescriptions dispensed in Canada be established and monitored with appropriate consumer safeguards.

Such a registry will cost millions to implement, said Ms Cooperstock, and "obviously will take time".

However, she noted that a similar recommendation came out of an August consultation in Levis, Quebec, on women, alcohol and drugs, sponsored by the Canadian Foundation on Alcoholism and Drug Dependencies.

"The more frequently this kind of recommendation is made, the more the federal government will pay attention to it."

More easily implemented, she suggested, would be the one addressed, among others, to the Industrial Task Force at ARF.

It states that literature and film used in industrial programs recognize the alcohol-related problems of women employees and that as a preventive measure, women's groups be formed within the work setting to define and discuss their problems and receive mutual support.

"There's no reason that couldn't be implemented very quickly," said Ms Cooperstock.

Other composite recommendations centre around education of health workers, equalizing of opportunities for women in medicine; continuing education of health workers; and reorganization of health care to increase the number of health units working under a global budget and allow other health care workers to meet the needs of chemically dependent people.

The final recommendation, addressed to ARF, NMUD, and the Donwood Foundation, says institutes dealing with women with alcohol and drug-related problems establish an affirmative action committee to set quotas for women in management within a specific period of time.

The Ottawa consult was organized by ARF, Eastern Ontario, and the Ontario office of Non Medical Use of Drugs Directorate.

They do not qualify as hospitals

US insurers dropping alcohol programs

CHICAGO — Some alcoholism treatment programs seeking accreditation under a newly-devised system of national standards are being dropped by health care insurance carriers because they fail to qualify as hospitals.

At the annual meeting of the Alcohol and Drug Problems Association of North America, Uwe Gunnerson, director of the alcoholism division of the Joint Commission on Accreditation of Hospitals, (JCAH) said that to some of the insurers, the presence of a surgical suite, a laboratory, and other hospital appurtenances seemed synonymous with good care.

Yet JCAH accreditation standards emphasize that "an alcoholism program need not be in a hospital setting in order to qualify for accreditation".

"It has been demonstrated that all types of programs from the smallest inebriate program to the rural halfway house can qualify for accreditation under these standards," says JCAH.

The standards, adopted by the alcoholism division of the Accreditation Council for Psychiatric Facilities (AC/PF, a subgroup of the JCAH) were developed with the input of a broad range of experts in the alcoholism treatment field.

Accreditation in this context is purely voluntary and is meant to help programs clarify and determine goals, monitor services, and develop improved programs. To date, this is the only nationally-recognized measurement of the quality of care provided in alcoholism programs.

The accreditation process for alcoholism programs is still young, having started in the fall of 1974. But the problem of interpretation about what constitutes alcoholism treatment, and subsequent endorsement by third-party agencies, is clearly one of the major stumbling blocks to be faced thus far, except for the fact that alcoholism program administrators have not exactly broken into a stampede to achieve accreditation.

So far the JCAH accrediting body has done about 120 surveys. Until the spring of 1975, slightly fewer than 50% of those programs surveyed achieved accreditation, some for two years, others for one.

Gunnerson is clearly uneasy about the hesitant response.

"When it comes to accountability we (in the alcoholism field) are very vulnerable," says Gunnerson, "Hospitals have been in the accreditation game for many years, their procedures are geared to that need. We are not. We have to catch up.

"Accreditation is not panacea. It is only one among many steps that we have to take in the next five years if we are to put ourselves on the map (in terms of) the total health care field in this country."

MILAN KORCOK
reports from the annual meeting of the Alcohol and Drug Problems Association of North America, in Chicago

These early ventures in the accreditation process by alcoholism programs are being watched closely by some individuals in the field of drug abuse treatment, now that an analogous set of standards has been prepared and is being tested by the drug abuse division of the accreditation council for psychiatric facilities of the JCAH.

(AC/PF also has programs that accredit adult psychiatric facilities, children's and adolescents' psychiatric facilities, as well as alcoholism programs.)

Salvatore (Sam) di Menza, director of the drug abuse division of JCAH notes the standards are being pilot-tested by 88 programs in the field. The testing is being funded by NIDA.

Actual accreditation (which, as with the alcoholism programs, is voluntary) is expected to begin when results from the pilot tests are in, possibly in the summer of 1976. To date, 150 programs have volunteered to participate in the project.

In an earlier statement, di Menza emphasized the importance of developing nationally-recognized standards at a time when public accountability of health services was becoming so critical — especially with the advent of national health insurance.

Di Menza has noted that some states have expressed interest in incorporating some parts of the accreditation standards into their state licensing regulations. (Licensing regulations are those which empower a facility to carry on practice in a given jurisdiction. Accreditation is a means of providing a yardstick by which programs can measure their own service capabilities.)

"Funding sources and licensing bodies that make use of the standards in this way, do so independently of the JCAH," said di Menza.

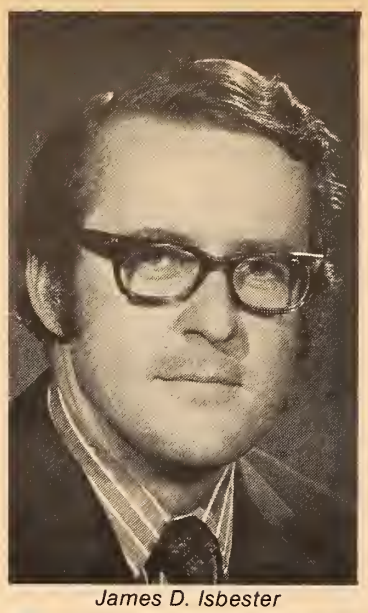
Integrate or else, Isbester warns

CHICAGO — When national health insurance finally becomes a reality in the United States, alcohol and drug abuse treatment programs had better be solidly integrated into the health care system.

This warning came from James D. Isbister, administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), in a keynote address to the annual meeting of the Alcohol and Drug Problems Association (ADPA) of North America.

The future of many existing programs may well depend on whether they qualify as providers of reimbursable services, and in order to do that they will have to prove they are doing a worthwhile job in a cost-effective fashion, said Mr Isbister.

Urging alcohol and drug program participation in the national health insurance dialogue, he emphasized: "The stakes are very high. The benefits included will be profoundly influential on all of your programs over the long run."



James D. Isbester

Speaking of alcoholism and drug abuse services, Isbister said: "The question is not whether they should be covered, but to what extent. Their exclusion from insurance would be bad medicine and bad economics," he said.

The extent to which such services are included, however, depends upon many variables, especially how well they are integrated into the medicare care, general health care, and social welfare systems.

How the third-party insuring agencies define inpatient, outpatient, and intermediate care, will also be critical to the insurability of many programs, he said.

It is only reasonable to expect that providers of care, insurers, and citizens, look for criteria and standards against which to measure services and decide which are to be insured.

"Standards must be maintained in any health system, with the providers accountable to the public," he said.

In many areas of health care, legislated standards for quality control are being introduced. This, said Mr Isbister, involves guarantees of adequate care through certification of providers and facilties.

The search for such criteria must place even greater emphasis on the need to develop and refine satisfactory licensing and accreditation techniques for alcohol and drug treatment programs, and for the certification of workers in these programs.

"New public financing efforts, taken together with improved benefit packages under private insurance, especially for alcoholism, place increasing demands upon us to improve the management of our programmatic activities and develop better accounting systems . . . in order to garner third party reimbursement.

"We will all be much more accountable in the future than we have in the past about both cost effectiveness and actuarial data."

Certification is on the way

(continued from page 1)

and contemplate and weave the perfect system. It is past the point of ventilating and discussing."

The ADPA decision to convene the series of meetings had been anticipated since June when the board of directors adopted a policy calling for action in the matter of national certification.

That policy statement noted that "some states and local organizations have or are establishing standards for (addiction) counsellors, and procedures for the accreditation of facilities sometimes include certain standards or background requirements for counsellors.

"There are no nationally recognized criteria of necessary minimal skills and experience for counsellors, and no national certifying body."

In its call for a national certifying effort, the ADPA policy statement claims: "A national certifying body is essential to assure minimum standards of care for citizens with substance abuse problems; it is essential to provide clarity of position and status for addiction counsellors, and to allow for lateral as well as vertical mobility; and it will expedite the coverage of chemical dependency treatment through third party funding sources, enhance the assurance of coverage for addiction problems under pending national health insurance legislation, and provide a basis for a higher degree of standardization from state to state."

The policy statement notes that though the states themselves must be legally responsible for licensure and certification of counsellors in their respective jurisdictions, a national certifying body can provide standards which the states themselves might adopt.

Uwe Gunnerson, director of the alcoholism division of the Joint Commission On Accreditation of Hospitals, stressed the need for speedy follow-up on the ADPA's action.

"This is something that has been lagging and has to be picked up very rapidly. Time is running out, and there is no more time for complacency."

Counsellors should be ogres— with marshmallow hearts

By GERRY HILL

QUEBEC CITY — Motivating the female alcoholic to stop drinking demands confrontation, harshness and a very tough attitude — at least on the surface.

Such an approach can "turn out to be the nth degree of kindness when it succeeds," Mrs Lorain Rostant, director of Quebec's Beaver House Rehabilitation Centre told the annual meeting of the Canadian Foundation on Alcohol and Drug Dependencies.

She also questioned the need for handling women in separate facilities and said treatment outcome at Beaver House improved when men and women were accepted and treated regardless of sex.

She challenged new workers in the treatment field to make better use of their own personal anger and frustration which stems directly from trying to 'help' the female alcoholic.

"Thank God for the new workers who keep arriving. You are desperately needed, for this is an endeavour that saps the energy," she said.

"I would ask that you rush into and reach with outstretched arms the addicts you wish to help. Help them, support them, run about for them as quickly as possible.

"And when you have become totally frustrated, and question your abilities and choice of work — take all that anger and frustration and use it on the very patients that have been using your good intentions.

"You'll find that this will work in a positive way with at least 50% of them and will be very good for you."

Mrs Rostant, who has been working in alcohol treatment programs for 15 years, said head-on confrontation was crucial and must be based on searching out and involving the people who themselves mean the most to the person with the problem.

"If female alcoholics are vulnerable to anything, they are open to deep, personal losses as a result of their illness — their husband or children if they are married, or the job if they are single and self-supporting."

Once the key person or influence is identified and his or her continuing support becomes questionable, the female alcoholic loses her "Ace in the Hole".

"We motivate this very person to use his or her anger on the lady and tell her she must choose between the bottle or me — the bottle or the job. Nothing less than this harshness will reach her," Mrs Rostant said.

"It's undoubtedly true that some 'housebound' women may die before help reaches them or, at best, be 'exposed' to help when they have reached the point of no return, a good reason for frequent treatment failures," she said.

"Every member of the family must be reached and made to realize that by protecting grandmother, sister, wife etc., they are, in fact, destroying the very person they are trying to protect."

Mrs Rostant wants more effort by professionals in the field to focus news media attention on the issue.

Pituitary Opioid Peptide

'Fantastic' find

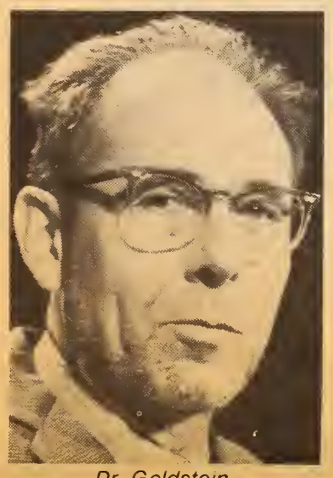
By MARY HAGER

PALO ALTO, CAL. — After several years of searching, a team at the Addiction Research Foundation here has identified a substance that acts like morphine and exists in the pituitary gland of several different mammals, including human beings.

The precise function of the substance — which has been labeled Pituitary Opioid Peptide, or POP — is still obscure. But foundation director Dr Avram Goldstein has suggested POP may be involved in the control of pain, in the response to stress, in moods and emotions and in "natural euphoria and well-being".

"I suspect this may be a normal system for how we cope with environmental stresses," he said. "That's what is so fantastic about this."

Dr Goldstein, a pharmacologist, believes the discovery could lead to the synthesis of a new class of opiate-like drugs for the relief of pain.



Dr. Goldstein

And he believes the discovery may have important implications for the heroin addict, as a lack of the substance could explain why some people are particularly vulnerable to heroin.

Or, a "feedback mechanism" may be involved so the presence of an unnatural opiate, like heroin, would block synthesis of the natural substance, he said.

In that case, withdrawal symptoms and cravings could be due to a lack of POP, and the reason so many addicts have trouble keeping off heroin could be that it takes POP synthesis a long time to return to normal, he said.

POP and morphine differ chemically, but both seem to act on nerve tissue in the same way and form the same kind of chemical bonds in the same place in nerve tissue, he explained.

The search for POP began in 1971 when Dr Goldstein, a professor of pharmacology at the Stanford University School of Medicine, discovered there were specific opiate receptors in the mammalian brain. The distribution of these receptors corresponded to the "pain pathways" of the brain.

He postulated there must be a reason for their presence — that an endogenous opiate-like compound must exist.

"It would only be logical, as it is not likely the receptors were put there in anticipation of opium poppies," he told **The Journal** in an interview.

All known neurotransmitters were tested, he recalled, but the opiate receptors were found to be highly specific, like locks which could only be opened with certain keys.

The only known "keys" that fit the receptors were substances derived from opium poppies or synthetic opiates.

Apparently, the substance Dr Goldstein and his team were seeking needed both the physical and the biological properties of an opiate.

Consequently, they determined the substance they were seeking must meet two criteria: It must have the same effects on nerve tissue as an opiate, effects which are selectively blocked by the powerful morphine antagonist nalaxone; and it must be determined, by the use of radioactive materials, to combine with the receptors.

Many compounds were tested, but nothing met both criteria, he said. As many neurohormones are peptides — even though opiates are not — the team started looking for a peptide that would fit. They even built models of peptides that would fit the receptors and synthesized a few, but nothing worked, he said.

Then, a "serendipitous accident" occurred.

The team ordered some ACTH to test because a published report had suggested that ACTH, a pituitary hormone, affected morphine activity in the spinal cord of the cat.

But no pure ACTH was available, so some impure "grade B" material was tested. It met the criteria.

Later, pure syntheitic ACTH was obtained and tested, but it did not pass the tests, he said. This led to the conclusion that it was not the ACTH, but some "impurity" they were looking for.

The team then extracted from the impure material a compound — a basic peptide composed of about 14 amino acids — that did meet the criteria, Dr Goldstein said. The compound was found first in porcine pituitary material and later in pituitary material from beef, sheep, rats and humans.

As all known pituitary hormones are present in all mammals, POP is almost certainly also present in all mammals, he added.

Now the compound has been isolated, next steps will be to determine the structure and to synthesize it, said Dr Goldstein. Then studies can be done to determine the precise function of the compound and whether it is, indeed, involved in control of pain, stress response, moods and emotions.

A different compound, but one which seems to have the same properties, has been isolated in Scotland. And similar work is being done in Sweden and at Johns Hopkins University.

Members of Dr Goldstein's team at the Addiction Research Foundation are Dr Brian M. Cox, Dr Kent Opheim and Dr Hansjorg Teschemacher. The work was reported in a recent issue of **Life Science.**

Doctors must understand ways of Native Canadian patients

By DOROTHY TRAINOR

BANFF — General practitioners and psychiatrists must begin to study the social and cultural backgrounds of their Native Canadian patients if they are going to help them.

This is the opinion of Dr Wolfgang Jilek of the department of psychiatry, University of British Columbia.

Dr Jilek was one of 32 Canadian psychiatrists who spent two and a half days recently on an Indian Reserve some 40 miles from Calgary meeting Native Canadians and discussing their most pressing problems, including alcohol and drug use.

The encounter was arranged through the Canadian Psychiatric Association's task force on native people's rights and coordinated by Dr David J Lewis, acting director of the department of psychiatry, University of Calgary, and Roy Littlechief, president of the Calgary Urban Treaty Indian Alliance.

The psychiatrists slept in teepees and, at night, sat with their hosts round a campfire in informal "give and take" sessions. Days were given over to more formal discussions about the psychosocial problems of the native people, said Dr Jilek.

The two- and-a-half day meeting at Stoney Indian Wilderness Camp, immediately preceeded the Canadian Psychiatric Association's annual meeting here.

In his opening address to the meeting, Dr Jilek said: "The Indians' plight — and this must be clearly stated here — was created by the white man's intrusion into well-functioning aboriginal culture with admirable social institutions, largely destroyed by the process of westernization."

Later at a press conference, he said one thing had become very clear at the meeting at the camp: It is vital for family doctors and psychiatrists to begin to understand the ways of their Indian patients if they are going to be able to help them.

In a formal paper to the CPA meeting, Dr Louise Jilek-Aall, (Dr Wolfgang Jilek is her husband) who has worked with west coast Salish Indians said: "They have little, if any, notion of the function of a psychotherapist. To them, a psychiatrist is still the alienist who manipulates crazy people".

She said Native Canadians often react with apprehension to the usual questions put to them by therapists. However, their silence is often seen as hostile defiance rather than the fear reaction that it may be.

"They know this kind of interrogation so well from their dealings with the police."

The meeting at Wilderness Camp included Indians from Arizona, Montana, British Columbia, Ottawa and the American-Indian Studies Center, Seattle.

Although the 32 psychiatrists intend to report to the CPA and make recommendations as a result of their encounter, no formal report has yet come from the group. They say they want to avoid making hasty decisions.

The CPA task force on native people's rights plans another meeting between psychiatrists and representatives of Native Canadians next year, possibly in Quebec.

Routine urine screens

Gross errors go unseen

BANFF — An American researcher claims routine urine screens in methadone programs are both too costly when one considers aggregate costs and too often inaccurate.

Dr Edward Gottheil, professor in the department of psychiatry and human behavior, Jefferson Medical College, Philadelphia, told the Canadian Psychiatric Association's annual meeting: "If regular urine testing is to be continued, then it would appear mandatory to ensure that all treatment personnel at methadone clinics be made aware of the fallibility of results.

"Current federal regulations stipulate that in methadone programs, urine specimens from all patients must be tested at least weekly for opiates and monthly for amphetamines, methadone and barbiturates. Other drugs are tested for as indicated.

"The regulations also require that the tests be done in laboratories that participate in the proficiency testing program of the Center for Disease Control (CDC), US Department of Health, Education and Welfare.

"It has been estimated that there will be in the neighborhood of 30 million urine samples tested for drugs this year."

Even at a cost of between $3 and $5 each, he said, the total cost amounts to about 10 times as much as the total budget for alcohol research.

There are distinct clinical disadvantages to using inaccurate urine tests results, he said. The most important of these are the deleterious effects on the therapeutic relationship when the individual is wrongly accused to taking drugs, and when tests fail to detect drugs that are present. Some therapists also question the clinical usefulness even of accurate results — considering them dehumanizing.

Another problem is that to increase quality control would increase costs. He said that it might be argued that instead of investing so much time, effort, and money on routine and regular urinalyses, it would be better to increase counselling staff.

"We strongly believe federal regulations requiring regular urine testing and CDC proficiency testing programs should be reevaluated and serious consideration given as to whether they should be changed or possibly even discontinued."

Considering the time and costs involved in obtaining and testing urine samples, as well as the importance placed on results, it is surprising there have been so few reports on reliability and validity of these tests, he said.

"The CDC evaluates the proficiency of participating laboratories on a regular basis. However, they use small numbers of samples, usually 10 specimens containing one, two, three and four drugs, which are sent in a manner to be recognizable at the laboratories as test samples.

"Even under these known test conditions, in one CDC survey of 208 laboratories, only 59% received satisfactory scores (80 - 100), while the remaining 41% scored less than satisfactory and in some instances much less than satisfactory.

"In view of these results, what level of proficiency should we expect of these laboratories in their routine day-to-day operations? If we use the judgement of our patients as a guide, then the proficiency must be quite low.

"Some counsellors are aware of the fallibility of urine tests, while others are not. Few realize the degree of gross error."

More Canadians refusing to give breath samples

OTTAWA — More Canadians suspected of drinking and driving and then stopped by police are refusing to provide breath samples as required under the breathalyzer legislation.

At the same time, the number of Canadians caught driving while impaired is also steadily climbing, despite the breathalyzer legislation.

According to the latest crime statistics released by Statistics Canada, there were 12,933 infractions registered in 1974 involving the failure or refusal to provide a sample of breath. Measured as a function of every 100,000 Canadians, this translates into a crime rate for this offence of 58.0 for 1974.

This compares with a rate of 49.0 in 1973; 38.2 in 1972; 25.8 in 1971; and 19.1 in 1970, when less than one-third as many people were charged with the offence.

The impaired driving rate for 1974, meanwhile, hit 595.4 per 100,000 population, compared to 537.2 in 1973; 459.7 in 1972; 420.6 in 1971; and 358.4 in 1970.

Preliminary traffic enforcement statistics for the first quarter of 1975, compared to the first quarter of 1974, showed these two offences dropped slightly in frequency, as did most other traffic offences. No reasons are given for the drop.

Meanwhile, the crime rate per 100,000 population for cannabis offences rose to 223.1 in 1974, compared to 193 in 1973 and only 61.1 in 1970.

The crime rate for opiate drug offences dropped to 15 in 1974 from 17.2 in 1973. But the rate in 1970 was only 4.8.

Perhaps for the same reason, statistics for the first quarter of 1975 show the same sort of slight drop in the crime rate for cannabis and opiate offences as for the traffic offences.

The statistics are not broken down by age group, though they are broken down by province.

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IN MEMORIAM IWY

JUST TWO months to go and we all can relax. International Women's Year will be over.

Interesting, stimulating. Occasionally even amusing. Just about everyone, for instance, had or heard a ribald laugh at some stage about the government's chief contribution to the year — the slogan Why Not? They may also have heard the rumor that in 1976, the new buttons would read Not Bloody Likely.

But that's the way many will remember it. And they will think, and even say,: "That's it. We've listened. Now get on with it and let the rest of us get back to reality." To be fair, there will be women as well as men thinking this way.

In the alcohol and drug field, as in almost every other, awareness of women and their problems increased this year. Women seemed suddenly more obvious, more prominent. For as much as any other reason, perhaps it was simply because they were now beginning to be seen as something more than a research sub-section on wives, mothers or daughters of alcoholics. They were beginning to be seen as people with their own problems.

In the context of the emphasis everywhere on women, the focus on them in this field probably created the mistaken impression that an inordinate amount of time and energy was being devoted to their needs.

Women are "cutting themselves off", "doing exactly the same thing men have been doing", some people said.

Their aims are fine, they said, but their tactics . . . Implicit in the unfinished statement was the suggestion women needed a few men to show them how to get things done.

These people, and they include women, thought they were seeing their fears confirmed when, in August, in Levis, Quebec, the Canadian Foundation on Alcohol and Drug Dependencies held its consultation on women and, in September, when the ARF's Eastern Ontario regional office, with the aid of the Non Medical Use of Drugs Directorate, held a provincial consultation on women with alcohol and drug problems.

The first was attended by men and women representing the field across Canada. They spent three days discussing its inadequacies in relation to women and in a burst of enthusiasm and with the innocence of pioneers of a sort, they came up with some 50 recommendations for improvements.

The Ottawa group met about a month later. It was the first and only officially convened formal meeting of women about women with alcohol and drug problems in this province ever.

Older and wiser after Levis, organizers distributed working papers beforehand and participants were asked to consider nothing but the facts — even if the fact was there were no facts. This time, there were 20-odd recommendations — all of them eminently sensible, sensitive and responsible.

Questionable tactics? For wives, mothers, recovered alcoholics, single women, career women — just women — to meet for the first time and to spend many solid hours discussing how other women with alcohol and drug problems could better be helped? To come up with good solid recommendations for improvements? To send them through the established channels to where the power to change, refine and improve the system as it exists, lies? Hardly.

It's called working within the system to improve it. And if it isn't the socially approved method of accomplishing things in this society, then we are mistaken about how society works.

Not, of course, that the "awareness", the meetings or the recommendations have actually changed anything — yet.

But, when the famous year is over and the jokes forgotten, or just a slightly grating memory, those who recognize improvements are needed, will have convinced more than each other that they are right to go beyond the beginning.

— Anne MacLennan

Why wait?

THE ARMY marijuana study (page 16) is an important contribution to our knowledge of cannabis.

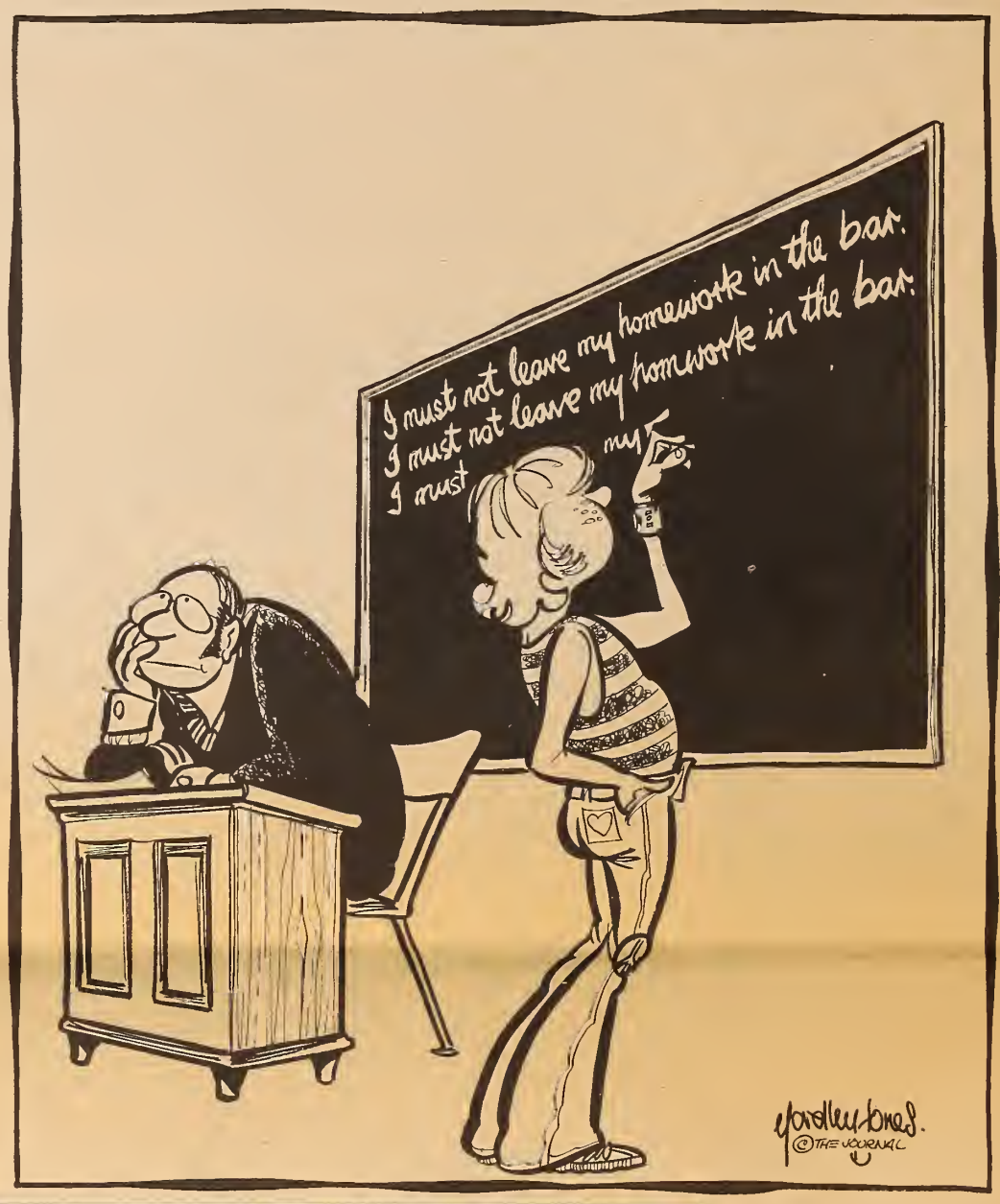
Like the Ganja in Jamaica study it addresses a critical set of questions. But why was its release delayed?

NORML has charged the study was deliberately suppressed because the data did not support the position of the hawks.

Others might indulge in a bit of cynicism about the fact that as the anti-marijuana forces gathering about the Eastland committee in the summer and fall of 1974 were being given full media exposure, a report of this magnitude was sitting, gathering dust. Well, maybe.

The army is to be commended for sponsoring this research, and also for being the first government agency off the mark in responding to NORML's request for information.

But it does itself a disservice by failing to follow through so as to make information as widely accessible as possible.



Letters to the Editor

Sir:

A spokesman for the Addiction Research Foundation of Ontario has said that among teenagers surveyed who drank, 75% of their fathers and 40% of their mothers approved of drinking.

On the other hand, he said most persons under the age of 19 who did not drink lived in homes with parents who did not agree with drinking.

Ann Landers, who receives thousands of letters each week, recently said the most heart-wrenching letters come from children of alcoholic parents. It is clearly up to the parents to set the example. "Do as I say and not as I do" will not wash with today's young people.

William E. Rae
Scarborough, Ont.

Bird's-eye view at Helsinki

Sir:

Wayne Howell's way of commenting on the report of the Helsinki congress, (**The Journal**, September) makes me think that he attended so many international congresses he got tired and now prefers the bird's-eye view.

Or, maybe he is simply one of those hard-working declared anti-congressionalists.

Anyhow, he and some readers of **The Journal** may still be interested in the real raison d'etre of the fourth major conclusion about alcohol education of the Helsinki Institute.

(To quote the conclusion correctly: . . . "It is therefore regarded as highly undesirable to discard alcohol and drug education at this stage in any country where such programs are under way. Instead more experience and study must be gathered, particularly in the schools, where it must be ensured that teachers are trained adequately so that they can carry out this education.")

Some policy makers having heard of the failures or the doubtful effects of alcohol/drug education in schools, are eagerly using these sounds to curtail funds for educational activities and experiments or even to stop these altogether which subsequently could result in apathy and waiting for the moment of scientific truth.

I think, and apparently I am not alone, that it is a good thing to take a stand on these far from unrealistic possible development.

C. Goos
Federatie van Instelligen
voor Alkoholen Drugs
Postbus 171
Bilthoven, Netherlands

CODA enjoys fiscal health

Sir:

Your recent editorial on "Fiscal Reality" dealing with the problems of the CFADD, (**The Journal**, October) irresponsibly links CODA with the financial problems of other organizations in the drug abuse field.

If you would do some homework, you would find that CODA is in an excellent financial position, supported well both by the private sector and the Ontario Government.

Further investigation would also reveal that CODA's programs both for students and teachers have received such an overwhelming response for bookings that CODA's staff are taxed to fulfill all requests.

Further investigation would also reveal an interlocking directorship now exists between CODA and ARF. Dr. W. Boothroyd, ARF acting executive director, appointed by Premier Davis, has been a director of CODA for several years and now the Hon. Frank Miller, Minister of Health, has appointed our Chairman, Mr. Frank Buckley, as the CODA representative on the ARF Members of the Foundation. This will prove an interesting venture in cooperation.

Perhaps the point of this letter is to suggest to you that you

Backgrounder

By GARY SEIDLER

THE SPRING of 1976 is an important date in the calendars of 1,700 resident members of Synanon as well as many prestigious individuals associated with San Francisco's powerful Hearst Corporation.

In cases complete with exconvicts, drug addicts, charges of payoffs and stolen tapes, Synanon will square off against the San Francisco Examiner (once the proud flagship of the Hearst chain) in a $32 million libel suit. A separate criminal conspiracy suit, worth several more millions of dollars, has also been filed.

At Synanon, the suit — launched four years ago — has taken on a life of its own. The entire community seems plugged into circumstances and personalities surrounding the case, while six Synanon lawyers devote most of their time preparing for the courtroom battle.

For the controversial Synanon organization, the stakes may be the difference between life and death. Quite apart from the substantial amount of money involved, Synanon appears to be looking forward to identifying its enemies, clearing its name, and using the opportunity to prove its efficacy and value as an effective drug rehabilitation program (**The Journal**, October, 1975).

Certainly, the opponents are a perfect ideological match; a radical communal organization which considers itself a school for a totally new way of living versus a Conservative right-wing newspaper.

The law suit concerns itself with two allegedly libelous Examiner articles. In the first, January 13, 1972, Synanon is described as the "Racket of the Century".

The article, written by Robert Patterson, is based on an interview with a former drug addict named Guenther Nuerenberger about his seven-month stay at Synanon facilities in Oakland and Tomales Bay.

Synanon claims in the law suit that the Examiner article suggests Synanon fraudulently obtains money, mismanages funds, utilizes false accounting for funds and expenditures and diverts charitable funds to private benefit.

Further, Synanon is charged with deluding the public — "because most of those who pour funds into its coffers suffer from the delusive misconception that the well-publicized organization has the cure of addicts as its raison d'etre. This was once so but no longer true."

Synanon, the article continues, specializes in providing a zombie-like existence for fugitives from reality and has no specific therapy program for addicts.

It goes on to charge that Synanon rips off newcomers for everything they're worth, serves its residents discarded meat and vegetables, bought a $190,000 home for its founder and director Charles "Chuck" Dederich, "phases out" addicts, and a series of equally devastating allegations.

Synanon
versus
Hearst's San Francisco Examiner

Synanon charges that the Patterson-Nuerenberger front-page blast is false, malicious and defamatory in its entirety and that everybody at the Examiner connected with the story knew this was so.

Nuerenberger's credibility and the degree to which it was checked by the Examiner is one of the basic issues in the libel action.

As required by California law, Synanon asked for retractions of both articles. (A second article states the Internal Revenue Service is investigating Synanon and implies the charity might lose its valuable tax-exempt status). The Examiner refused and the suit was filed October, 1972.

In their answer to the libel, Examiner attorneys deny the allegations made by Synanon and indicate the paper will rely on the defences of truth and statutory privilege and also on constitutional defences under the 1st and 14th amendments to the US Constitution; namely that the paper did not write the story with malice (i.e. with knowledge that it was false or with reckless disregard for the truth).

A major attraction in the whole affair is reporter Patterson, no stranger to controversy.

Patterson, a convicted felon twice fired previously by the Examiner for various fabrications, has given members of the Hearst family one big nightmare.

When first hired by the Examiner in 1945, Patterson had already spent several years in prison. He served sentences for robbery, grand larceny, embezzlement, confidence games, forgery and passing bad cheques.

Patterson wrote a spicy society column in the Examiner before his criminal record was uncovered and he was fired by William Randolph Hearst in 1949.

But, somewhat mysteriously, Patterson was rehired in 1967, a move approved by Randolph Hearst, son of William Randolph Hearst — who had since become boss of the Examiner.

After writing a series of exposes involving welfare chiselers, homosexual scandals and the like, Patterson presented Nuerenberger's version of "Synanon: Racket of the Century".

Seven months later, Patterson was fired again by the Examiner — this time for fabricating a series on "inside China" . . . some say from a bar stool in Hong Kong.

For what they have termed a "Dirty Tricks Campaign", Synanon has also filed a criminal conspiracy suit which undoubtedly will await the decision of the earlier libel action.

The conspiracy, Synanon claims, involves the Examiner paying burglars to break into Synanon offices to steal tapes, inducing the Wall Street Journal to withhold publication of a favorable story on Synanon and rehiring hatchet-man Patterson after he was twice fired.

Interestingly, reporter Patterson is once again being bankrolled by the Examiner.

Since the Synanon suit was filed in October, 1972, Patterson has been retained by the Examiner as an investigator for $250 per month.

Synanon, of course, charges that Patterson, now in his late 60s and in ill-health, is simply being "kept" for his testimony.

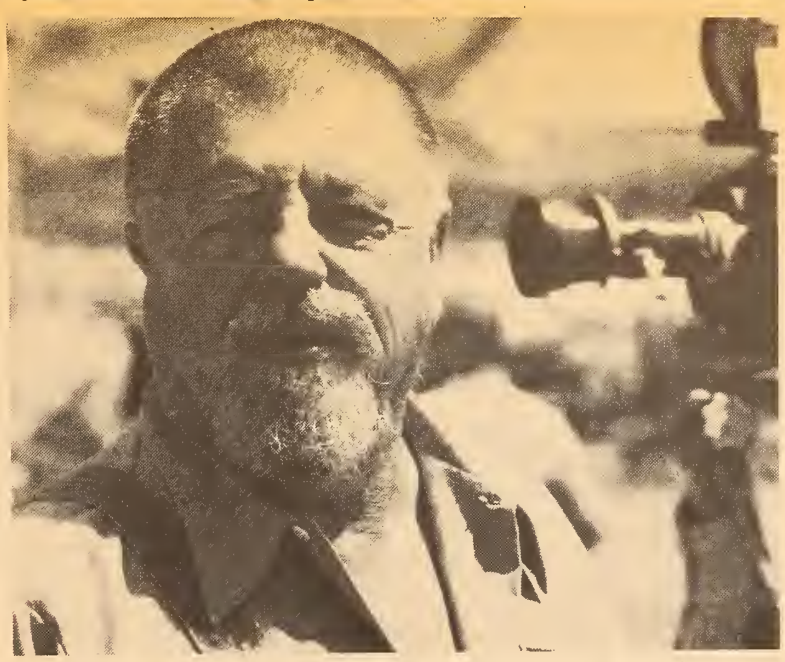
Dan Garrett, head of Synanon's legal staff, believes reporter Patterson swallowed the story of "an obvious crazyman — a bug". The Examiner supposedly paid Nuerenberger $150 for his story and Synanon attorneys intend to prove that Nuerenberger sold the story because he needed the money.

The most serious of the Synanon charges is to the effect that Examiner attorneys directed the hiring of a trio of thugs to steal tapes from Synanon offices. If sustained, such a charge could be devastating to all concerned.

Media coverage of the various allegations involved in the Synanon versus Examiner case has been conspicous by its almost total absence.

Even though it involves perhaps the largest current libel action in the United States, only the San Francisco Bay-Guardian, which offers itself as an alternative to the establishment newspapers, has provided any continued and detailed coverage of the case.

If, as suspected, the libel action goes ahead next spring, the case will provide observers with several useful opportunities; to view life at Synanon, life at the Hearst Corporation and life in the U.S. of A.



Synanon founder Charles "Chuck" Dederich

really make an effort to update your knowledge of the Council on Drug Abuse. Then you might live up to your objectives, briefly listed in the box on the same page "To our readers".

E. A. Westendorp
President
Council on Drug Abuse
56 Esplanade Street East
Toronto, Ontario M5E 1A7

Fighting the fight

Sir:

Your story heading, "Gov't. purses fattened by alcohol sales", (August), may inadvertently help to perpetuate one of the entrenched myths about alcohol consumption.

To suggest or imply that the taxpayer or society benefits financially from alcohol sales is misleading and destructive. This unrealistic view is likely one of the major factors preventing our politicians from taking steps which might affectively alter the trend towards increasing consumption and alcoholism.

If society is ever to respond realistically to the growing problem of alcoholism it must have access to and face the facts. A good beginning might be to tackle the illusion that society somehow benefits financially from the sale and consumption of alcohol in its various forms.

Is this not a responsibility of organizations such as the Addiction Research Foundation and its publications, including **The Journal**? Mr. Archibald (ARF executive director) listed some of the monetary costs in his 1973 statement entitled: Changing Drinking Patterns in Ontario — Some Implications. Obviously this isn't enough, perhaps because it is buried among other consideration and is far from a complete listing.

Leaving aside social and health costs, what are the actual or real monetary costs to society of excessive drinking? Surely organizations like the ARF have the ability to determine these and make them known to politicians and the public. How urgent is the responsibility to do so and where does one begin?

Politicians are subject to lobbying and other influences that reflect the vested interests and voices of a largely uninformed public. Perhaps it is time for the ARF to balance this input by taking a more aggressive role in bringing the facts to the politicians and those they represent, regardless of the political implications which may be involved. Doing so would be an important step in fulfilling it's responsibilities and within the mandate for which it was established.

Noe I. Beauchesne,
Program Consultant
(Ottawa office) ARF

Appreciation

Sir:

I am writing to express my appreciation for **The Journal's** coverage of our summer conference, "Behavioral Approaches to Alcoholism and Drug Dependencies" sponsored by the University of Washington Alcoholism and Drug Abuse Institute. Anne MacLennan is to be congratulated for her accurate and stimulating series of articles which appeared in the September issue.

Readers of **The Journal** may be interested to know that cassette tape recordings are available of all the talks given at the conference.

C. Alan Marlatt, Ph.D.,
Conference Coordinator.
Department of Psychology
University of Washington
Seattle, Wash.

By Wayne Howell

AN INTERVIEW with E. R. Bottomsworthy, professor of law, in which are cleared up some questions of modern jurisprudence re violent crime and alcohol use:

"Professor, recently an Ontario resident who stabbed his wife with a knife was acquitted on a charge of attempted murder because after considering the psychiatric testimony, the court held that the man was too intoxicated to have formed a homicidal intent. So it appears that if you wish to stab your wife — and I imagine this applies to wives and family members as well — there are certain advantages in being blotto at the time."

"Yes, definitely. Of course if you are blotto then you are incapable of performing the act. The trick is to be blotto enough to satisfy the court that you are incapable of forming the intent, but not so blotto that you sink your knife into something that turns out later not to have been your wife."

"I see. Now professor, recently the Ontario Criminal Injuries Compensation Board refused two victims of violent crimes compensation for their injuries, their pain , and their suffering, because they (the victims) were intoxicated when the crimes were committed against them. So it would appear that you would be out of luck if someone were to stab you while you were drunk."

"Yes, definitely. And if the person who stabbed you was himself so drunk as to be incapable of forming the intent to stab you — the knife went off by accident as they so often do — then not only would you lose out on the financial compensation end, you would not even have the satisfaction of seeing your assailant pay for his crime."

"I see. Now what would happen if your wife were to stab you while drunk?"

"Who's drunk — you or your wife, the stabber or the stabbee? As you can see, it makes a difference."

"Let's say both are drunk."

"Well in that case your wife would be in pretty good legal shape, providing of course she could prove in court she had considerably more than 0.08 in her bloodstream. But you would be out of luck on two counts — and perhaps a third, depending on where she put the knife. You would be out of luck because you were drunk and you would be out of luck even if you were cold sober because the Ontario Criminal Injuries Compensation Board does not consider the scars of marital mayhem to be criminal injuries. Now if a third party were to be involved that, of course, would be a different situation."

"A different situation . . . ?"

"Yes, definitely. Recently the Ontario Criminal Injuries Compensation Board awarded compensation to a man who had been badly beaten by two thugs hired by his wife. Husband and wife were subsequently reconciled and received, in effect, a conjoint award. However, if you really want to maim or injure someone, your best bet is still to get drunk and then run him or her down in the street with your car.

"The penalty for that is still only a slap on the wrist."

Acquiring "the habit" in France

North American Lynn Payer, our Paris correspondent, used to drink water. In France, she's switching to wine. It's easier to get, and cheaper.

PARIS — A century ago, a wealthy Englishman named Wallace came to Paris and found he was obliged to pay for a drink of water. So shocked was the good gentleman that he donated the city a number of graceful fountains; and the city supplied them with potable water from the city supply.

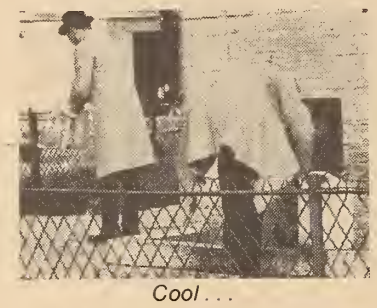
One hundred years later, some of the Wallace Fountains are still around, but it is rare to see anyone using them. And it is still almost as difficult to get a glass of water in a Parisian cafe or restaurant.

I discovered this when I came to Paris four years ago. Kitchenless, and on the tight budget of a free-lance journalist, I often ate out in inexpensive restaurants. I began ordering cheap wine with my meal, sometimes because it was a novelty, but often, when I would have been just as happy with water, because wine was the cheapest beverage on the menu, cheaper than water or any other non-alcoholic beverage. Now, I order wine because I want it. The habit is perhaps not serious, but it is, nevertheless, a habit.

This, in a native of Kansas, the home state of Carrie Nation and the state that to this day outlaws the serving of drinks in airplanes flying over it. This, in someone who at the age of 12 refused to order in a French restaurant because everything was cooked in wine. This, in **The Journal**'s Paris correspondent.

* * *

The difficulties of obtaining water in Paris are both social and economic. The social difficulties pre-dominate when trying to order faucet water, or **l'eau du robinet**; the economic



Cool . . .

ones with bottled water, or **l'eau minérale**.

When I first came to France, it was the consensus of the educated but non-medical public, that faucet water was dubious. Although a few of the more sophisticated French doctors had assured me that Parisian water is quite acceptable, except perhaps for the taste, non-medical friends advised me to avoid drinking it.

With this mentality, plus a growing public awareness of the harmful effects of alcohol, the French have become the world's largest consumers not only of wine, but also of bottled water. Consumption rose from 505 million bottles in 1950, to 2,189 million in 1971.

While in grocery stores mineral waters are usually cheaper than wine, in restaurants and cafés they may well be more expensive.

An example: A restaurant priced ¼ litre of red wine at 1.80 francs, ¼ litre of mineral water at 2.20 francs.

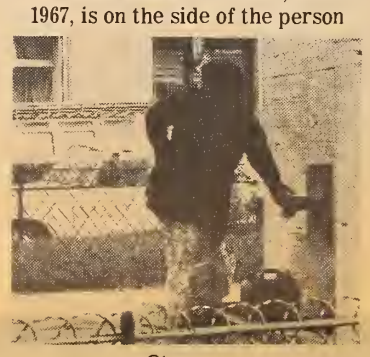
The economic police found in a 1966 survey that in cafés a glass of wine was sold at 1.8 times cost, a glass of pastis at 1.5 time cost, a cup of coffee at four times cost, and mineral water at five to six times cost. Behind this practice is a law, established for the profit of the wine growers, that makes it practically impossible to retail a glass of wine for more than twice its cost.

In recent years, consumer organizations have pointed out that besides being several hundred times more expensive than faucet water, mineral water is also often inferior. As in many other countries, bottled water is less strictly controlled than are the public water supplies and often have such a high mineralization that they would not meet the standards for potable water.

In addition, perhaps because of plastic bottles, bacterial counts are often higher in bottled water; and there have even been reports of worms in one of the brands served most commonly in restaurants and cafes.

Adding to the insult of paying for an inferior product, is a built-in North American (and apparently English) resistance to paying for water at all, the remembrance that even during the worst drought years in Kansas, when bath water was not to exceed two inches and each person had the right to flush the toilet no more than once a day, no one was ever denied a glass of water!

Why, then, not simply ask for **l'eau du robinet?** The law, since 1967, is on the side of the person



Clear . . .

who does so. Custom is not.

Certainly, I can understand why it isn't appreciated if one orders **only** faucet water: prices in cafés must be regarded as being in large part rent for the table. And while I initially rebelled at being denied faucet water as my only beverage in restaurants, I now understand what lies behind this: prices are often set so that profits are not made on food but on beverages. Thus, in a restaurant I have learned to conform to custom, usually by ordering wine.

What I still cannot accept is the difficulty of getting faucet water when I am already paying for food and beverage and simply want some water to go with it.

* * *

Was I the exception, or do the French also begin drinking wine because it is cheap? Is cheap wine merely a trap for innocents abroad used to free water on demand, or is it a major cause of French cirrhosis? And would tampering with the economics, making water cheaper than wine, be able to cure the nation?

The Comité National Contre L'Alcoolisme has as one of its objectives the promotion of non-alcoholic beverages, and in 1969 signed an agreement with the nations café owners whereby certain non-alcoholic beverages — "boissons pilotes" — would be offered at prices similar to that of wine.

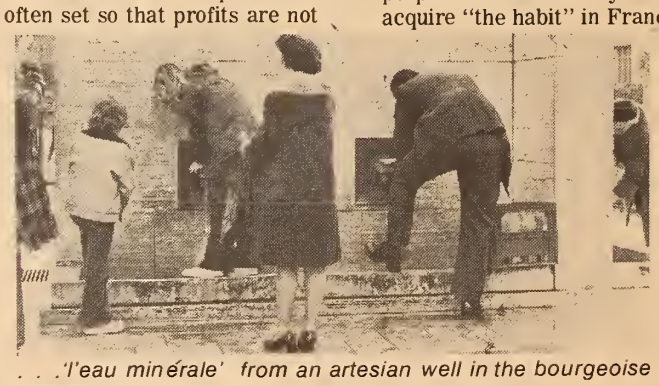
Dr Jacques Godard thinks the program has largely been a failure, because the French have not used the operation **boissons pilotes**, just as they have not used the Wallace fountains.

Furthermore, says the CNCA official, proclaiming that wine is cheaper than water is just an excuse, since in grocery stores this is not the case.

My own impression as an inveterate café-goer is that the café-owners have played their role in the failure, and that it is as hard to get a **boisson pilote** for the listed price as it is to get water.

Where my own experience would seem to converge with the more global view of Dr Godard, however, is that regardless of whether people drink because alcohol is cheap, or alcohol is cheap because people drink — it is very easy to acquire "the habit" in France.

The author's local café framed by a deserted Wallace Fountain.



. . .'l'eau minérale' from an artesian well in the bourgeoise quartier.

Around the world

THE YOUNG COUNTRY

Young people in England are now being tempted by advertisements in two of their favorite publications, *Sound* and *Melody Maker*, to buy T-shirts bearing the Canadian Club whisky motif on the front, and the slogan — "the taste of the young country" — on the back. They cost about $4.50 and a spokesman for the company promoting the shirts says the offer has met with "considerable success".

SICK DOCTORS

The problem of the "sick doctor" has been highlighted in the UK by a report by a 15-strong team headed by Dr A W Merrison, vice-chancellor of Bristol University. It says alcoholic, drug dependent and mentally ill doctors are treating patients every day and that doctors are three-and-a-half times more likely to die from cirrhosis of the liver than the general population.

HUNGARY SMOKERS

Hungary has banned cigarettes in primary and secondary schools to cut down smoking by teenagers and compulsory lessons on the health dangers of smoking have now been made part of every school's curriculum. The ban also applies to teachers in school hours.

CURB STIRS

Regular drinkers in India have become concerned about future imbibing since the government announced recently it had decided to begin "preparing the ground for the introduction of total prohibition". New rules, being enforced erratically, include a ban on drinking in public places although there has been confusion over what should be considered "public".

SAUDIS BUY BRITISH

A British brewery is trying to develop a non-alcoholic beer to sell in Saudi Arabia where people are not supposed to drink because of their Moslem religion. Although several countries produce non-alcoholic beer, the Saudis want English beer because they regard it as best.

AN ACRE OF ALE

The biggest alehouse in the world is what the great Victorian Doric flower market of London's old Covent Garden became recently when 33 different brewers from Scotland to Cardiff invited "real ale" devotees to sample the "non-gaseous ales our grandfather enjoyed". The pub-for-a-week covered about an acre and the most devoted members of Britain's rapidly growing Campaign for Real Ale group gave up a week's holidays to serve.

PINK ELEPHANTS

Wild elephants have been gorging fermented fruit and going on drunken rampages through a Tanzanian game reserve. Game rangers reported seeing them trumpeting, screaming, knocking down trees, and chasing other smaller animals.

At 12 industrial plants

Soviet 'addiction divisions' working out well

By **JOHN DORNBERG**

SOVIET SPECIALISTS in the treatment of alcoholics reported "good results" from an experimental program that combines work therapy with drying out.

The program, set up three years ago, calls for establishing so-called "addiction divisions" at 12 industrial plants in Moscow province.

Alcoholics under treatment at nearby psychiatric hospitals are sent to live and work there. The patients work full shifts and are paid on a piece-rate basis at regular rates.

They live in special dormitories on the plant site and are under constant medical care and observation. Their earnings are paid for out of hospital and medical insurance funds, rather than by the factory. Part of the earnings are deducted for hospitalization requirements and the patients' upkeep.

Since the patients' trades and skills may not be those needed by the 12 factories that have joined the program, they are apprenticed to learn new trades and specialties. The plant pays for the training and provides the patients with work clothing and tools.

Assignment to the therapy program is voluntary and presupposes patient willingness to come to grips with the drinking problem.

Each of the divisions has about 100 patients. Their direct supervisor at work is a psychiatrist who, ideally, also has manufacturing and industrial experience.

The therapy program is scheduled to last three months, after which patients are discharged though they are kept under continuing medical and psychiatric observation for a two-year period.

Patients whose treatment is judged to be "proceeding successfully" are entitled to weekend out-patient privileges to visit families, go to movies and the theatre. Those who relapse are subject to a variety of punishments ranging from assignment to less skilled and less remunerative work to expulsion from the program and discharge from the addiction division.

Divisions have been set up at a variety of plants with work ranging from the manufacture of semi-conductors to the production of buses and cotton-picking machines.

According to Dr. R. N. Murashkin, chief psychiatrist of Moscow Province (the administrative area around the city itself), who reported on the project in the government's daily newspaper Izvestia: "Hundreds of people are being treated at any given time in the addiction divisions which have been established."

The Soviet Ministry of Health has concluded that the program is "more than twice as effective" as standard treatment of alcoholics at regular psychiatric institutions.

Euphoric chewers urged to quit

Betel nuts pose problem in New Guinea

By LACHLAN MACQUARRIE

PORT MORESBY — In addition to the challenge of political independence, the 2½ million people of Papua New Guinea face another major task — trying to give up the widespread practice of chewing betel nuts.

Recently the government launched a campaign to educate the public about the connection between using the highly-valued, euphoria-producing betel nut and the high incidence of mouth cancer in this country.

The basic ingredients of the betel quid are the nut itself, the betel leaf, and slaked lime. The nut is obtained from the areca palm *(areca catechu)*; the leaf from the betel vine *(piper betel)*; and the lime is processed from coral, shells, or mountain lime.

So popular is betel chewing that users devote much care and attention to their "betel nut sets" which include a hollow gourd container with a spatula for the lime, a box or metal case for the nuts and leaves, and clippers for cutting them. All of this is customarily carried by chewers in plastic airline flight bags.

The ripe fruit of the areca palm is about the size of a large cherry and brown in colour. The nut itself is like nutmeg with hot, acrid and aromatic properties.

Chewers enclose this nut in a betel leaf together with a little lime. The combination is put between the teeth and the cheek wall, pressed with the tongue and sucked.

This is said to have an abrasive action with a masochistic component which adds to the basic euphoria derived from the drug's action as a cerebral stimulant.

Dr B. G. Burton-Bradley, writing in the *Medical Journal of Australia*, notes that it is the alkaloid *arecoline* in the nut which is responsible for its euphoric properties while the volatile oils of the betel leaf have anaesthetic properties and a strong pungent odour reminiscent of cloves. The lime has an astringent effect and produces a chemical change which aromatizes the mixture and yields the red colour of the saliva.

The beginner experiences a feeling not unlike that of a beginning tobacco smoker, including dizziness, vertigo, nausea and cold perspiration.

However, the unpleasant symptoms soon diminish and, with development of the habit, a feeling of euphoria and well-being spreads through the entire body when the nut is chewed. Feelings of hunger, tiredness and irritability disappear and there is an increased capacity for work. Another popular effect is that chewing gives a pleasant odour to the breath.

As for negative effects, Dr Burton-Bradley claims that for the vast majority, withdrawal symptoms are not significant and "betel nut addiction is uncommon".

He does point to a few "predisposed personality types who discover that the stresses and strains of life become insupportable without the aid of a chew, and who like true addicts need a continuity of supply".

"These established chewers are in a state of drug dependence from which they cannot easily be retrieved", he states.

Dr Burton-Bradley also refers to betel nut psychosis which he describes as, "an acute reversible toxic psychosis characterized by auditory hallucinations and grandiose or persecutory delusions which occur in a person predisposed by either a former head injury or a genetic history of mental illness". He describes these negative symptoms as "extremely rare".

Much more serious, according to government health officials, are the cancer-producing effects of betel chewing.

Health Department statistics, based on a Cancer Registry started in 1957, show clearly that in Papua New Guinea, where an extremely high proportion of the population indulges in betel chewing, the incidence of mouth cancer cases is among the world's highest.

Dr L. Atkinson, writing in *The Diseases and Health Services of Papua New Guinea*, published by the Department of Public Health here, points out that, "it has been established that cancers constitute a major health problem in Papua New Guinea. Deaths from this cause rank third in numerical order.".

Regarding the relationship between the betel nut and cancer, Dr Atkinson notes that the connection was established very quickly by the Cancer Registry and the figures have been confirmed over the years.

Vodka more accessible than beer and pop

USSR effort hits 'familiar snags'

By JOHN DORNBERG

DESPITE KREMLIN edicts and Communist Party resolutions, the campaign against alcohol consumption in the Soviet Union appears to be running into familiar snags.

Although the government is pushing and advocating the consumption of beer and soft drinks instead of vodka, their sale and distribution remain inadequate and haphazard.

The troubles, on a small scale, were described by a group of workers at a metallurgical plant in the town of Nizhny Tagil in the Urals recently in a letter to the editors of Pravda.

"Our brewery," they wrote, "has been in operation since 1971, but beer is unavailable for long periods of time. If any is brought to some kiosk or other, a long queue of customers forms immediately. But who wants to stand in line for an entire hour to get a mug of beer?

"When the brewery opened, beer was sold from kvas barrels. (Kvas is a slightly fermented grain beverage, sometimes called the Russian Coca-Cola. It is usually sold from tanks and huge barrels on street corners.) Customers brought their own pitchers, bottles and containers and it was sold on a 'carry-out' basis.

"But this was called 'primitive' and 'un-hygienic' and stopped. However, no other method was substituted.

"There are very few kiosks and stalls equipped with beer glasses or mugs. There is a little shed next to Store No. 28 on Parkhomenko Street which sells beer on tap, but there is always a long queue.

"We also have a tavern, but it won't sell you beer unless you also order a snack.

"Why not organize the sale of beer as it should be organized? It's a refreshing drink, especially when you've worked in a hot steel mill all day. But in a more decent environment, not a shed. Why not put some tables under a tent in a public park or open a pavilion?

"What amazes us," said the three workers who signed the letter, "is that there is plenty of vodka in the stores in our town and no lines to get it — to the detriment of beer and non-alcoholic beverages."

BARS CLOSED IN RUMANIA

MUNICH — In a massive drive against alcohol consumption and abuse, the Romanian government has announced its intention to close down 2000 bars and taverns throughout the country.

They are to be turned into restaurants, quick-lunch places, bakery shops and pancake houses.

Some are to restricted to the sale of dairy products, vegetarian cuisine and diet meals.

The majority of bars and taverns that are to be closed are located near schools and factories.

Manitoba works on public awareness

WINNIPEG — Manitoba's campaign to motivate alcohol consumers to more moderate drinking is having more effect than similar efforts in other provinces, says J. Frank Syms, chairman of the Liquor Control Commission.

Mr Syms told **The Journal** in an interview that the commission's program calls for increased public awareness messages in most of the areas in which breweries and distillers were able to advertise in the past — particularly on televised or radio-broadcast sports events.

"As they vacate the field — and as you know it is no longer possible for the breweries to run commercials during hockey games on television in this province — we get in there with our commercials for moderation in drinking," said Mr Syms.

"We feel we are doing an excellent job in this field and we are having an effect already."

Public awareness advertisements and commercials started in Manitoba earlier this year. An effectiveness survey by the commission in the summer showed that about 7% of respondents have been encouraged into more moderate consumption, while 14% were "turned off" by the messages.

Two hundred individuals were selected for the survey, 170 of them in Winnipeg and 30 in Brandon, Man.

Results showed that 82% of those who answered the questions had noticed the liquor commission advertising. Of these, 74% saw the ads on television, 32% heard them on radio, and 27% read them in newspapers.

The phrase "One drink on the table at a time" attracted most notice, with 79% of those questioned recognizing it. "Nice and easy does it every time" came second with 66%.

By MANFRED JAGER

The advertisements were designed and filmed in Saskatchewan and the Manitoba Liquor Control Commission bought them for use in this province, with only parts localized for Manitoba purposes. Neither ads nor commercials were recognizeable as having come from elsewhere.

Messages were considered good or average by 77% of those questioned and poor by 3%. They were favored by 50% of respondents and opposed by 14%.

About 44% believed the messages increased awareness of harmful drinking patterns and 58% felt they helped change attitudes to drinking at least to an extent. Seven per cent said their own drinking habits had changed since the ads and commercials appeared.

Neither moderation messages nor the commission survey to test their effectiveness, seem to have removed all major concerns about Manitobans' drinking habits, however.

Jim Hershfield, research officer with the Manitoba Alcoholism Foundation, said in an interview that despite efforts by the commission, more people are drinking more alcohol in Manitoba than ever before.

He said nearly 45,000 Manitobans consumed hazardous levels of alcohol in a one year period ending April 31, 1974, and that figure is growing rapidly. About half the 45,000 must be classified as "out-and-out alcoholics," said Mr Hershfield. (Manitoba's total population is slightly more than 1 million.)

Comparing figures from a 1974 Manitoba Liquor Control Commission report to a similar survey made in 1970, Mr Hershfield said there has been a "fantastic rise in consumption".

"The average drinking adult's consumption has risen by 21% in four years."

Hazardous drinkers take nine ounces of liquor or six beers daily — enough to cause liver damage, heart disease and some forms of cancer if continued a long time.

The 1974 report estimated there were almost 22,000 adult alcoholics (aged 15 or older) in the province or about 6% of the total adult population.

Mr Hershfield described at last half the alcoholics as employed and middle-aged. A small percentage are of the skid-row type, he said.

"Alcoholics are the type of people found in treatment and detoxification centres. Of course we don't get everyone we consider an alcoholic in for treatment."

MDs must curb prescribing habit:CMA head

OTTAWA — Canadian doctors should spend a little more time talking to their patients and a lot more questioning the moral, ethical and professional basis for the "tranquillizer on demand" approach to emotional complaints, according to the executive officer of the Canadian Medical Association.

Dr J. D. Wallace, secretary-general of the CMA warns that unless physicians start doing something voluntarily to curb the use and abuse of prescribed tranquillizers, the medical profession might end up watching the government step in with strict controls, as happened a few years ago with amphetamines.

He notes that formerly when a patient said he or she was worried, the doctor took time to discuss the problems of the patient. Often this was either sufficient reassurance that the patient did not need any other treatment; or the discussion would lead to a more thorough medical examination.

"This, while time-consuming, was good medicine." Dr Wallace says.

But now "tranquillizers have apparently become the 'in' thing for almost all emotional complaints."

What's perhaps worse, patients are now demanding tranquillizers for their "anxiety"... a modern bit of terminology meaning "worries".

The prescription and consumption of tranquillizers has reached "alarming proportions", with the drug industry selling more tranquillizers than any other family of prescribed medicines. They account for 4% of all new prescriptions and refills in Canada.

Tranquillizers used properly, can be very helpful drugs, Dr Wallace says.

"Chronic alcoholics who previously suffered through prolonged and traumatic withdrawal symptoms during the 'drying out' stage can now stop drinking and often 'stay dry' through the proper use of tranquillizers."

But when abused, "even the so-called minor tranquillizers (which are usually the ones prescribed on demand) can be hazardous," he says.

"They may not be addicting in the narcotic sense. But the fact that they are habituating is proved by the troublesome withdrawal symptoms when discontinued after extended use."

California Bar proposal

Free heroin plan

LOS ANGELES — The San Francisco Bar Association is considering a program for the free distribution of heroin, it has been announced here.

In a statement to the annual Conference of Delegates of the State of California, the San Francisco group said use of heroin should be treated as a medical and social problem rather than a criminal act.

Not only are present heroin laws failures, the group said, but they help fatten the bankroll of organized crime and can even be blamed for increasing the crime rate.

The group asked the Conference of Delegates to request that the Legislature appoint a special committee to study the proposal.

In its proposed heroin resolution, the San Francisco Bar said: "It is obvious a new approach to heroin is needed.

"The use of heroin should be approached as a medical and social problem not a criminal act."

Despite controversy about Britain's free heroin system, the association said the program "is continuing without the need for the addict to resort to criminal acts to support his habit and without the role of organized crime in the distribution process."

The resolution emphasized heroin use was not being condoned but said there must be "attempts to deal with the problems of such use in a meaningful way".

Noting the failure of the present public policies on heroin, the association said: "Dealing with heroin addiction by the criminal process has isolated the user from society by making him a criminal and has so greatly increased the cost as to make its marketing irresistible to organized crime."

Hyperactives studied

BANFF — The prognosis for hyperactive children with respect to alcohol and drug use in adulthood appears much the same as for matched control subjects, according to a Montreal Children's Hospital study.

The 10-year follow-up study compares 25 controls and 35 hyperactives in childhood and 10 years later.

A preliminary report, presented at the Canadian Psychiatric Association's annual meeting here, suggested there are no significant differences between the two groups with respect to slight or moderate use or abuse of non-medical drugs. No differences have been found with respect to patterns of alcohol use.

Drs Lilly Hechtman and Gabriel Weiss of the department of psychiatry, with three research associates, are conducting the study.

A new way of getting around. . . . the message

Advice centre on wheels

FAIRFAX, Va — The "Boozemobile" is the latest thing in alcohol education.

The sign on the camper van parked in the neighborhood shopping center reads: "So who has a problem?"

Inside the van, rather than "Dear Abby" or "Ann Landers" are members of the Council on Alcoholism for Fairfax County answering questions — particularly from youth — about alcohol and drinking behavior.

The van, festooned with balloons and bottles, welcomes the curious, those with personal drinking problems, and those who are having difficulties because of alcohol abuse in their immediate families.

The mobile counselling unit also hopes to promote responsible drinking attitudes among those who have, or will have to make a decision around whether or not to drink.

The Council's executive director, Ralph Patton, makes it clear his group is not promoting abstinence but attempts, through alcohol education, to help young people make knowlegeable decisions when it comes to responsible drinking or not drinking.

In addition to providing a variety of alcohol literature, counsellors refer visitors to various local facilities for assistance with specific problems.

Psychiatrists need teaching

BANFF — Psychiatrists must seek greater understanding of the conditions that bring about a rise and fall in such phenomena as alcohol and drug dependence, violence, and crime and alienation, and their relationship to biological, social and psychological variables.

This was the counsel of Dr Colin M. Smith of Regina in his presidential address to the Canadian Psychiatric Association's annual meeting here.

Dr Smith is clinical professor of psychiatry at the University of Saskatchewan.

Learn the language of the poor, the oppressed and the downtrodden, look to your ethics and speak out more clearly and effectively on social issues, he told his colleagues. Psychiatrists must also teach their methods to other helping persons.

Better training in sociolinguistics, sociology, anthropology and psychology is required in the psychiatric field, he cautioned.

"However we must enter this area as pioneers rather than pundits and as researchers rather than social reformers.

"Many of the problems that affect people today appear to be characterized by a lack of meaningfulness in their lives rather than something that can be labelled as an illness in the classical sense."

Different strokes for different folks

By MARY HAGER

SAN FRANCISCO, CAL. — Just as different types of people are attracted to different types of drugs, different types of drugs have different types of markets.

These markets, and the reasons for their differences, have been analyzed by Michael J. Soref of the University of Wisconsin. He presented his findings at the recent meeting of the American Sociological Association.

Among the factors affecting the market structure, he said, are the difficulty of getting the drug from its source — whether that is a foreign country or a domestic laboratory — to the user; the success of law enforcement agencies in eliminating sources or disrupting distribution; the degree of addictiveness and consequent demand for a drug; the complexity of the distribution system; and the price, which may fluctuate if a drug is widely available, or be fixed and higher if the source is limited.

In his analysis of the markets as they have evolved since 1915, Soref said the heroin market is the most complex.

The difficulty of getting heroin from source to user, and stringent law enforcement measures, led to the development of a multi-level distribution system, which includes foreign growers and processors, importers, various "connections", weight dealers, street dealers, and "jugglers" who are both dealers and users, he said.

The price of heroin is high because distribution is concentrated among a few importers and all levels are seeking to make their "profit", he explained.

Marijuana, he said, is usually grown in Mexico, smuggled across the border by the "big dealer," and then sold to a middleman who supplies the street dealers. Psychomimetics and methamphetamines are synthesized in domestic laboratories, then sold to middlemen who cut it and sell it to the street dealers. Distribution and sales of the pshcyomimetics is more concentrated than for methamphetamines, since LSD manufacture is a complex process while methamphetamine synthesis is not.

The barbiturate market is highly diffuse as the drugs are legally produced and usually obtained directly from a pharmacy or wholesaler, making each user his own dealer, he said.

New Books

By RON HALL

The Social Basis of Drug Abuse Prevention

. . . by Richard Jacobson and Norman E. Zinberg

Drug Abuse Council, Inc. (1828 L Street, N.W., Washington, DC 20036), 1975. 128p.: $1.25

In this interim report of a project designed to explore the existence of a socially based drug education process promoting moderate use of illicit drugs, a model of alcohol education was used to develop a model of socially controlled drug use. The authors have suggested that the primary difference between the use of licit and illicit drug is the degree and kind of social structure surrounding the drug.

Sacred Narcotic Plants Of The New World Indians

compiled by Hedwig Schleiffer Collier-Macmillan Canada, Limited (1125 B Leslie Street, Don Mills, Ontario), 1973. index: 162p.: $6.50

As one of the five stated reasons for producing this anthology of texts from the sixteenth century to date, it is felt that an understanding of the role of narcotics in less advanced cultures may be beneficial in coping with current problems. The compiler has taken quotations from diverse points of view, has grouped them by family, and has indexed the work by names of genera, species, and vernacular names of plants and plant products.

A Manual On Drug Dependence

edited by J. F. Kramer and D. C. Cameron

World Health Organization (Information Canada, 171 Slater Street, Ottawa, Ontario. K1A 0S9), 1975. 107p.

This manual draws on various WHO publications and is intended to be of help to those professionals dealing with the problems of the non-medical use of dependence-producing drugs. Patterns of use, types of dependence, attitudes, management, and research are topics of discussion.

Other Books Received

Alcohol and Abnormal Protein Biosynthesis: Biochemical and Clinical: Rothschild, M.A., Oratz, M., and Schreiber, S. C. Pergamon Press, Inc., New York, 1975, 519p., $28.75.

Plasticity and Recovery Function in the Central Nervous System: Stein, Donald G., Rosen, Jeffrey J., and Butters, Nelson. Academic Press, Inc., New York, 1974, 516p., $22.40.

The Answer to Addiction: Burns, John. Harper & Row Publishers, New York, 1975, 232p., $7.95.

Handling Narcotic and Drug Cases: Bailey, F. Lee and Rothblatt, Henry B., The Lawyers Co-operative Publishing Co., Rochester, 1972, 549p., $43.75.

Heroin Dependency: Medical, Economic and Social Aspects: Stimmel, Barry. Stratton Intercontinental Medical Book Corp., New York, 1975, 304p., $27.00.

Principles of Pharmaceutical Marketing: Smith, M. C. Lea and Febiger, Philadelphia, 1975, 440 p., $17.95.

Realms of the Human Unconscious: Grof, Stanley. The Viking Press, New York, 1975, 257p., $17.25.

Behavioral Toxicology: Weiss, Bernard, and Laties, Victor G. (eds.) Plenum Press, New York, 1975, 469p., $45.45.

Twelve Young Women: Southerby, Norm and Southerby, Alexandra. Norm Southerby & Associates, Long Beach, 1975, 157p., $4.95.

The Epidemiology of Non-Medical Drug Use: Central Treaty Organization (CENTO), Ankara, 1975, 245p.

Drug Development and Marketing: Helms, Robert B. American Enterprise Institute for Public Policy Research, Washington, 1975, 300p., $9.00.

Volunteers: The Untapped Potential: Carter, Novia. The Canadian Council on Social Development, Ottawa, 1975, 169p., $3.50.

New approach to teaching front-line practitioners

By WALTER NAGEL

CALGARY — A new approach to the teaching of addiction therapists and counsellors may emerge from a current study of summer school training sessions held here.

Ric Durrant, a community services consultant for the Alberta Alcoholism and Drug Abuse Commission, noted there is increasing concern that existing educational programs do not reach some professional groups active in the field. Lawyers, members of the judicial system and physicians are typical examples, he added.

Durrant headed program arrangements at a summer school seminar held for several days during August at the University of Calgary. Almost 400 people attended the 1975 sessions, the fourth in as many years.

He suggested that in future years, there is a possibility of separate meetings with a sharper specialist focus, designed to attract certain types of "front line" practitioners who are dealing with alcoholism and drug addiction.

Proceedings in the past have tended to have a sociological and psychological basis for discussion groups and guest speaker topics.

Durrant said he and colleagues who helped to plan this year's event have begun to consider other ideas for the future.

"We know we need to re-think what we are doing. Not that we're doing anything drastically wrong, but we've been doing it for four years now, and that doesn't mean we go on automatically to year five."

He said there are "a lot of other possibilities" which may assist the objective of better educational, treatment and counselling skills for workers who confront drug addiction and alcoholism.

A preliminary thought is that a traditional summer school be held every second year, with in-between annual meetings planned for specific topics or designated professional groups.

A principal concern has been the virtual absence of family physicians at past seminars, something which is particularly unfortunate because they are among the first to detect and to treat drug addiction of alcohol abuse.

"Our programs have not had very much for them. The way we do it now, we really can't," the AADAC official said.

Most people who have attended the four summer meetings in Calgary have been agency related personnel such as family counsellors, educators, public health officials, and personnel consultants in business or the armed forces. Planners were concerned that if a great variety of program topics was chosen, and material made too divergent, delegates would attend inappropriate portions and receive little useful information.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

Fourth Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct. 31 — Nov. 1, Atlanta, Georgia. Information: Mr. J. Douglas, ALMACA, Suite 350, 300 Wendell Ct., Atlanta, Ga., 30336.

Third Annual Conference of the California Association of Alcoholic Recovery Homes — Oct. 31-Nov. 2, Asilomar, Calif. Information: Joe Collins, Executive Director, CAARH, P.O. Box 5396, Santa Monica, Ca. 90405.

33rd Annual Convention of the American Association of Marriage and Family Counselors — Interdisciplinary Theme includes Addiction and Family Therapy, Nov. 7-9, Toronto, Ont. Information: AAMFC Office, 225 Yale Ave., Claremont, California, 91711.

Fourth Information and Feedback Conference — Nov. 12-13, Toronto, Ont. Information: IF Conference Committee, Counselling and Development Centre, York University, Toronto, Ont.

First National Conference on Occupational Alcoholism and Drug Abuse — Nov. 17-20, Ottawa, Ont. Jointly sponsored by Humber College and Addiction Research Foundation. Information: Jim Simon, ARF, West Toronto Branch, 4143 Dundas St. W., Toronto, Ont. M8X 1X2.

Symposium on Creative Sexuality — Study seminar of efficient and exciting use of sex counselling time with Drs. Noam and Beryl Chernick — Nov. 26-28, Toronto, Ont. Information: Creative Sexuality, Suite 400, 73 Richmond St., W., Toronto, Ont. M5H 2A1.

International Symposium on Alcohol and Drug Dependence — Nov. 29-Dec. 5, Bahrain, Arabian Gulf. Information: Archer Tongue, Executive Director, ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Substance Abuse Prevention Forum — Dec. 8-10, Omaha, Nebraska. Information: Mr. J. Kushner, Executive Director, Nebraska Commission on Drugs, State Capital Building, Lincoln, Nebraska, 68509.

Second Caribbean Conference on Strategies of Drug Abuse in Developing Countries — Feb. 1976, San Juan, Puerto Rico. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Third National Drug Abuse Conference — March 25-29, 1976, New York City, N.Y. Information: Joyce H. Lowinson, M.D., Chairperson, National Drug Abuse Conference, 1500 Waters Place, Bronx, N.Y. 10461.

International Conference on Alcoholism and Drug Dependence — April 4-9, 1976, Liverpool, England. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Seventh Annual Medical-Scientific Conference of the National Council on Alcoholism — American Medical Society on Alcoholism — April 9-10, 1976, Washington, D.C. Information: National Council on Alcoholism, Inc., 2 Park Ave., New York, N.Y. 10016, Att'n: Medical-Scientific Conference.

Sixth International Institute on the Prevention and Treatment of Drug Dependence — June-July 1976, Hamburg, Germany. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Canadian Conference on Youth, Society and the Law — June 7-10, 1976, Kingston, Ont. Information: Chairman, Canadian Conference on Youth, Society and the Law, 55 Parkdale Ave., Ottawa, Ont.

Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies — June 20-25, 1976, Toronto, Ont. Information: W. J. Gilliland, Conference Manager, Information, Addiction Research Foundation, 33 Russell St., Toronto, Ont., M5S 2S1.

11th International Conference on Medical and Biological Engineering — Aug. 2-6, 1976, Ottawa, Ont. Information: Conference Office, National Research Council, Ottawa, Ont. K1A 0R6.

Seventh International Conference on Alcohol, Drugs and Traffic Safety — Jan. 23-28, 1977, Melbourne, Australia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Medical Symposium on Alcohol and Drug Dependence — Aug. 21-26, 1977, Tokyo and Kyoto, Japan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Supports 'Ganja study' findings

US army study unveiled

By MILAN KORCOK

THE REPORT on long-term ganja smoking in Jamaica has hardly had time to gather dust and now another massive study on chronic marijuana use has emerged.

Sponsored by the US Army at a cost of $382,000, and conducted by Dr Jack H. Mendelson at the Mclean Hospital Alcohol and Drug Abuse Research Center in Massachusetts, the report on behavioral and biological concomitants of chronic marijuana use strengthens many of the conclusions made in the Ganja report, (**The Journal**, September) and sheds light on areas not covered in the Jamaican studies.

In effect, chronic marijuana use among heavy and casual smokers monitored in a research setting showed none of the "amotivational syndrome" so long claimed to be an effect of smoking pot.

Furthermore, no significant changes were observed in physical and laboratory assessments following smoking, there was no evidence of any significant adverse effects on cognitive or neurological function, and there were no adverse changes in testosterone levels as a result of chronic marijuana use.

The researchers noted some decreased capacity in work performance the day following smoking, but not to the point of being biologically significant. There also appeared to be some psychological changes that affected the way individuals interacted with each other, but not to the detriment of group behavior.

The researchers noted some impairment to lung function that prompted them to argue against use of this drug to persons with underlying pulmonary disease, though the changes could have been attributed to the smoking process per se. They also found significant weight gain among the smokers.

Several findings drawn from this body of research have already been reported.

The design

The experimental design involved constant monitoring, in a research ward of McLean Hospital, of 27, tightly-screened heavy and casual users, who were given free access to marijuana in return for work performed.

The heavy users had been smoking

THE BACK PAGE

marijuana for an average of 5.6 years, had started smoking while in their 17th year, and reported using the drug an average of 42 times a month.

The casual users had been smoking 5.3 years, had begun at 18 years of age, and had averaged almost 12 smoking occasions a month.

The subjects, four at a time, were put through a 31-day period — an initial five-day block during which they had no marijuana, a 21-day block during which they could buy and smoke all the marijuana they wished, and a subsequent five-day non-marijuana period. They served as their own controls, with baseline tests being run on them during the non-marijuana periods.

The research ward was fitted out with individual bedrooms for the subjects, a common activity room, and examination facilities.

Work program involved a simple button pressing device. To earn points, subjects would press the device — each response spaced one second or more apart. Each press would signal a point, and every 1,800 points could be exchanged for 50 cents at the end of the study, or for a marijuana cigarette during the free-smoking period. Purchase of one cigarette required one half hour of sustained work.

Each marijuana cigarette, .09 grams, contained 2% THC. All smoking was done under supervision.

Marijuana use, work and motivation

Though the marijuana literature is stocked with claims about the drug's depressant effects and its "amotivational" influence on behavior, such claims were not substantiated by the army studies.

Marijuana, in fact, interfered very little with work output. Both casual and heavy users often worked at very high rates both during and immediately after smoking. The peak smoking period (from 8 p m to midnight) was also the period of greatest work output.

Casual users averaged 2½ marijuana cigarettes per day, heavy smokers close to six.

The amount of smoking increased as the experiment went on, to the point that on the last smoking day, the heavy smokers actually consumed an average of 14 "joints" each. The subjects all knew ahead of time, it was to be their last smoking day.

Work outputs of both groups decreased the day following marijuana use. Heavy users showed less inclination to work the day after heavy marijuana use, and among casual smokers, the more they smoked the less they worked the following day.

The researchers, however, caution against too free a generalization of these findings, largely because of the potential influence on motivation exerted by the research setting itself.

As the experiment went on, sleep time increased, time devoted to work decreased, and there were some suggestions about boredom setting in.

"Under natural but uncontrolled settings, work output may not be significantly influenced," says the report. This clearly supports the major finding of the Jamaican study which showed that not only does marijuana NOT produce indolence, but also it is used with success to fuel the work ethic, and to encourage hard, tedious, repetitive work tasks.

Tolerance

Development of tolerance to the various effects of marijuana use has been a contentious area among researchers. Many studies have noted a tendency for consumption to increase after continued long-term use. This tendency has often been attributed to development of tolerance.

Tolerance to the subjective effect of smoking — the "high" — would induce the smoker to consume more and more to get a set level of intoxication. This rate of progression becomes important if it is ever conclusively proven that chronic marijuana use can be related to such physical damage as respiratory dysfunction, or to psychological dependence.

Using measurements of pulse rate as well as the subjects' own ratings of their "high", the researchers found the casual users (consuming between 15 and 30 mg of marijuana per day) showed no signs of tolerance developing. In effect, the "high" they were getting at the end of the smoking series was of the same intensity and duration as with their first smoke.

Among heavy users (consuming between 30 and 60 mg daily) the situation was different.

Pulse readings, and ratings of intoxication showed that as they progressed further into the smoking period, the intensity of high remained constant but the effect of each cigarette did not last as long. This was indicated by the fact that pulse readings immediately after a smoking period remained constant throughout the series, but 25 minutes after smoking readings tended to diminish as the studies went on.

What this essentially means, according to the researchers, is that "tolerance does not develop . . . to marijuana intoxication . . . unless rather heavy doses of delta 9 THC are administered repeatedly."

Taking it one step further, the researchers suggest the tendency of users to increase consumption over time, appeared not necessarily to be due to the development of any tolerance, but possibly to other psychosocial and environmental factors that would influence them to smoke.

Why did the subjects smoke more and more as the studies went on?

In their own words, because they were bored, because the drug was available, and because "being stoned helped me better tolerate the ward routine".

Physiological effects

Perhaps the most dramatic finding in respect to physiological consequences of smoking was that subjects gained an average of six pounds during the 21-day free-smoking period. (In the Jamaican study, smokers were an average seven pounds lighter than the non-smokers).

Of obvious concern to the researchers was the effect of smoking on lung function. Measurements of peak air flow showed significant increases in flow rate in 12 of 15 subjects — suggesting an acute, bronchodialtor effect of marijuana.

Another concern was that in pre-smoking baseline studies, six subjects showed decreased vital capacity. Since they had all been smoking marijuana for at least five years, this finding suggested "perhaps there may be chronic, irritative, inflammatory or other pulmonary disruptive process related to long-standing smoking of marijuana."

Testosterone

The research study's findings that high dose marijuana did not suppress testosterone levels in either casual or heavy users is bound to add to an already exuberant debate between Mendelson and several other researchers, primarily Dr. Robert Kolodny of the Reproductive Biology Research Foundation in St. Louis.

Dr. Kolodny has reported marked reductions in plasma testosterone levels among marijuana users.

Other reports linking reduced testosterone and marijuana have suggested chronic marijuana use can lead to enlarged breasts in males, as well as loss of or impairment of sexual and procreative function.

But the Mendelson studies refute many of these conclusions, largely on the basis of methodological peculiarities.

The Army report says in the Kolodny studies samples were obtained on only two different days, usually a month apart. Yet, testosterone levels vary widely in males, says the report. Consequently, time and frequency of sampling are of major importance.

The Mendelson samples were done daily, throughout the course of the studies.

Mendelson is also critical of Kolodny's reliance on the subject's verbal recollection of drug use, and the failure to carry out urine screening to detect the possible presence of any other drugs.

"It is at least possible that suppression of plasma testosterone levels observed by Kolodny et al may be related to ingestion of substances other than marijuana."

Cognitive and motor tasks

Use of marijuana among the casual and heavy users in the army studies has been shown to cause little impairment of cognitive and psychomotor activites.

Results of various assessments showed no cumulative marijuana-related changes and no acute marijuana effects on simple reaction time, perceptual flexibility, or psychomotor performance.

In respect to effects of use on short term memory and vigilance, results were not so clear cut.

Although smoking did not have any residual effects on short term memory, the acute effects of marijuana did interfere with the casual users' performance. It did not affect heavy users in respect to short term memory.

According to the researchers, the findings suggest the effect of marijuana on the acquisition and storage phases of short term memory (which require attention), may be the crucial factor in its effects on short term memory performance.

The group

The only significant changes marijuana use exerted on the group process was that it induced the casual users to talk less and to retreat into their own thoughts more.

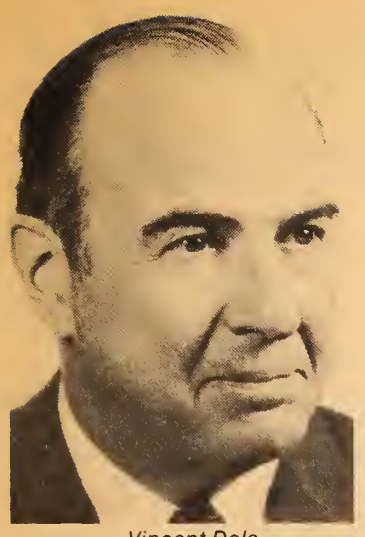
When intoxicated, the casual user showed he was more interested in his own thoughts than in those of others, but not to the point of abandoning the group.

Says the army report: "Although the absolute amount of interaction was reduced, intoxicated subjects generally did take part in the discussion, and their participation did not indicate they were incapable of communicating coherently and intelligently. Few anomalies in speech or expression were observed that could be related to marijuana intoxication."

Heavy users, on the other hand, showed no changes in respect to group behavior , except they seemed to laugh more.

It was said a little differently, certanly more lyrically, in the Jamaica-Ganja report which noted that those who prefer to smoke in a group usually go to the bush where they can enjoy "good and loving thoughts".

"I feel more merry, not lonesome."


Vincent Dole

In breast-feeding mothers

Methadone termination challenged

By DAVID ZIMMERMAN

NEW YORK — The gauntlet has been thrown down to pediatricians who prohibit new mothers on methadone from breast feeding their babies.

The challenge comes from methadone maintenance pioneer Dr Vincent Dole, of Rockefeller University and is based on a still-unpublished study by a Rockefeller colleague, Dr Mary Jeanne Kreek. She found that "virtually no methadone reaches the baby through the mother's milk".

In Dr Kreek's study, Dr Dole said, new mothers were found to put out between 17 and 60 micrograms per day of methadone in their milk. This is far too little to harm the baby, said Dr Dole.

Dr Dole presented Dr Kreek's data and his point of view on it at a symposium on substance abuse and maternal-child health sponsored by the New York City Addiction Services Agency and the New York County Medical Society late in October.

He said he was particularly "taken aback" by the policy in many neonatal nurseries of abruptly terminating a baby's nine-month exposure to methadone, a benign drug, and then exposing it to large doses of drugs like diazepam *(Valium)*, which has been shown to have toxic affects on neonates, in order to moderate their withdrawal symptoms.

In one case, he said, a baby was given 2,000 micro-

More reports — Page 7

gram/day of diazepam, which is five to 10 times the normal adult dose on a weight basis. The baby suffered convulsions, which Dr Dole indicated might well have been due to the

(See No Nursing — page 7)

The Journal

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Games of the XXI Olympiad **Montréal 1976**

Dope-testing 'wastes time'

By DOROTHY TRAINOR

MONTREAL — Dope-testing has gone too far and if doctors and other badge wearers would give the Olympics back to the athletes, everyone would be better off, an International Symposium on Sports Medicine here was told.

"Dope-testing is of dubious value. It is mainly a waste of time, money and effort to too little purpose," Dr Daniel F. Hanley said.

Dr Hanley is the US representative to the Medical Commission of the International Olympic Committee, deputy chairman of the International Association of Olympic Medical Officers, and chairman of the US Olympic medical and training services.

"At the Munich Olympics, 12 doping tests were positive in a field of 2,000 athletes. So ask yourself, what was accomplished and was it worth it?

"It would be nice to say that

(See — Dope-testing — page 3)

Drunk drivers face life bans

By GARY SEIDLER

TORONTO — Drinking drivers, particularly those who don't learn the error of their ways, will face penalties of up to lifetime driving bans if Ontario's new attorney-general has his way.

Roy McMurtry, who has grabbed newspaper headlines since his election this fall, recently vowed to clear the roads of drunk drivers.

See editorial page 8

Mr McMurtry stressed the lifetime driving ban would apply only to flagrant repeat offenders, and that tougher penalties should be complemented by a government program to educate drivers to the dangers of drinking.

Mr McMurtry's suggestion

(See — Lifetime — page 3)

The " war " is over

White Paper on drug abuse adopts realistic posture

By CHARLES MARWICK

WASHINGTON — The long-awaited White Paper on Drug Abuse may have deserved more attention from the public than it received.

Ordered by President Gerald R Ford in April from the US domestic council drug abuse task force, it has made no noticeable public ripples — a dramatic change from four or five years ago when almost anything on drug abuse was a major public concern.

Yet, while public attitudes about the drug abuse problem have changed, the problem itself has not, as the latest report makes abundantly clear.

What the report does do, however, is more than recount the drug abuse problem: For an official publication, it possesses a refreshing attitude.

For one thing, it admits that total elimination of drug abuse is impossible. What it recommends are holding actions and long-term commitments.

There is also an encouraging air of realism that has not characterized American official attitudes toward drug abuse in the recent past.

Gone from these pages, for example, is the "moonshot" philosophy and the militant language, the "wars" and the "beachheads" with which the Nixon administration tackled the problems of public concern, be they the subtleties of cancer or the depredations of poverty.

In their stead are phrases of reason, indeed of downright commonsense.

"We must be realistic about what can be achieved . . . all drugs are not equally dangerous . . . all drug use is not equally destructive . . . enforcement action should focus on the leaders of the drug traffic . . . (we) should move away from street level activities . . . while not letting up on reducing demand for drugs, treatment efforts should be supplemented with increased attention to prevention and rehabilitation."

The paper notes, in language that characterizes the entire report, that "the country must be prepared to continue its efforts and commitment indefinitely in order to contain the problem at a minimal level and to minimize the adverse social costs of drug abuse." In a word the strategy is containment.

There must also be better measures of the progress of drug abuse programs than addict counts, seizure records, or arrest statistics, all of which have been used in the past, the paper observes.

The paper itself studiously avoids such data. In large measure, this type of statistical approach to an evaluation of the national efforts against drug abuse is responsible for much of the ineffectiveness of these efforts, the paper says.

In the paper, drugs have been ranked according to their personal and social dangers, their capacity for inducing dependence, the severity of adverse

(See—Containment—page 2)

Urgent needs of women underscored by Rodino

By GARY SEIDLER

MIAMI BEACH — The urgent and unique needs of the woman drug abuser have been underscored by one of America's most prominent and respected politicians.

Astounded by the lack of research and literature relating to women and drugs issues, Peter Rodino Jr., chairman of the US House of Representatives Committee on the Judiciary, pledged his support to participants attending the first national forum on drugs, alcohol and women.

. . . "This pattern of neglect is extremely disturbing, especially when we consider some of the

More reports — Page 5

tragic consequences of female addiction.

"The human toll in terms of broken families, abandoned career and personal degradation is enormous and, quite often, there is a destructive impact on our youth," he noted.

Mr Rodino said treatment for women drug abusers has been typically based on what works for their male counterparts. It has even been suggested, he added, that treatment programs are male-oriented because the plight of addicted women presents less of an immediate threat to society than men who are more likely to be involved in violent street crime to support their habit.

"Whatever the reason, the result has been poorer success rates for women who, according to a 1974 study, drop out of treatment programs at twice the rate of men."

Mr Rodino called for a change in the present "imbalance" which restricts participation by women in the planning and decision-making for treatment programs.

"This, as much as anything else, has contributed to the insensitivity of these programs to the particular needs of women.

"At the same time, we must give our male staff members adequate attitudinal training regarding the special problems of female addicts.

"In short, there must be changes in attitudes toward women by society in general and by the medical profession in particular; there must be more women in decision-making positions in our governmental drug bureaucracy."

Mr Rodino urged participants at the national forum to undertake a comprehensive and continuous review and to convene additional conferences and seminars to address specific problem areas.

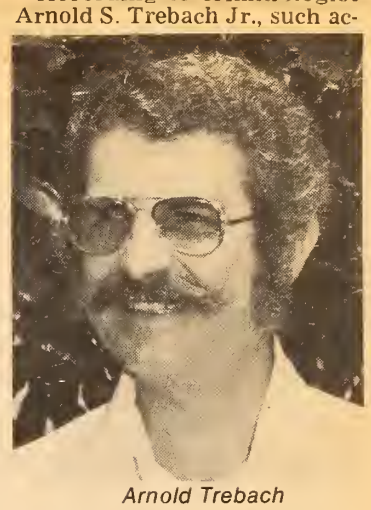
"At the same time, we should attempt to shape public opinion rather than respond to it, or to court decisions interpreting the constitutional rights of female drug abusers," he said.

Legal heroin system urged by law expert

By MILAN KORCOK

TORONTO — The introduction of a legal heroin distribution system in North America has been advocated as a means of reducing drug-related crime, and providing more effective care for the addicted.

According to criminologist Arnold S. Trebach Jr., such ac-


Arnold Trebach

tion would also allow heroin "the most powerful analgesic known to medical science" to be used in positive ways, such as for the relief of human suffering among non-addict populations, especially cancer and cardiac patients.

In an address to the annual meeting of the American Society of Criminology, Trebach urged a public action campaign to convince legislators to repeal the "prohibition" of heroin that exists today.

Trebach is professor, Center for the Administration of Justice, The American University, Washington D.C.

"This status of prohibition . . . has many of the destructive effects on the fabric of American society and criminal justice that alcohol prohibition had in the 20s."

(See — Legal — page 4)

INSIDE

Less a presidential concern

Drug issues move to cabinet level

By CHARLES MARWICK

WASHINGTON — Drug abuse control in the US is likely to become less a presidential concern and more a cabinet and department affair.

This is the direction of the present trend in federal programs dealing with drug abuse problems here, regardless of whether they are negotiating international agreements aimed at restricting supply; are involved in domestic efforts directed at reducing demand; or are engaged in law enforcement and regulatory activities involving illicit drugs.

The recently issued White Paper on drug abuse points out that the US government's activities aimed at drug abuse control are as diverse as any in government.

The federal effort to manage the problems involves no less than seven cabinet departments and 17 agencies.

"Clearly strong coordinative mechanisms are needed to ensure the efforts of these departments and agencies are integrated into an overall, effective program," the report drily comments.

When drug abuse control became a matter of high presidential priority in the early 1970's a variety of offices directly linked in one way or another with the executive office of the president was created.

For example, the Special Action Office for Drug Abuse Prevention (SAODAP) was created in 1971 to coordinate treatment and prevention activities as a balance to the then existing law enforcement activities. Similarly other offices were created for other functions.

Over the past few years, however, these have tended to be replaced by the more traditional agencies. Again, to use SAODAP as an example: This office is now replaced by the National Institute on Drug Abuse (NIDA) and SAODAP expired as scheduled this past June 30th.

Essentially the major agencies involved in the drug field in this country today are NIDA, which handles the prevention and treatment aspect; the Drug Enforcement Administration which deals with law enforcement; and the office of the senior advisor in the state department which manages international activities.

This decrease in direct executive office involvement is endorsed by the authors of the White Paper. However, they hold that there is still need for oversight and coordination at the presidential level. Accordingly one of their main recommendations is the creation of a Cabinet Committee for Drug Abuse Prevention (CCDAP).

This cabinet committee should be broad enough in membership to include both health, regulatory, and law enforcement representation at the highest level. For instance, the paper recommends that the chairman should be the secretary of health, education and welfare and its membership should include both the secretary of labor and the attorney general.

Another recommendation is the revitalization of the Strategy Council of Drug Abuse to provide overall policy guidance. This group was established in 1972 to assess the drug abuse problem, plan for a comprehensive response, and analyze the effectiveness of the major drug abuse programs. This effort should be continued in the view of the White Paper.

Even although a small executive office staff should still be retained to provide advice to the president, the paper recommends that this be gradually shifted to departments, agencies, and cabinet committees. The sum effort of these recommendations is toward integrating drug abuse control efforts at the administrative and cabinet level and a gradual phasing out of direct presidential involvement.

Containment is the strategy

(Continued from page 1)

consequences, and the size of the problem. Because of inadequate data, the paper admits these rankings are imprecise. Nevertheless a clear pattern emerges.

The leaders, by all odds, are heroin, amphetamines, and barbiturates, with cocaine, hallucinogens, and inhalants following in lower order. Marijuana brings up the rear.

On the basis of this rating, the paper recommends priority attention, in attempts to cut supply and to reduce demand for these drugs by proper treatment programs, be given to the three leading classes of drug since these pose a greater risk to the individual and to society in general.

This does not mean all the efforts should be devoted to those drugs and nothing to the others. Some attention must be given to all drugs of abuse both to keep their use under control and also because there are many problems among drug users of even a low priority drug such as marijuana.

The report recommends that reduction of the supply of illicit drugs be balanced with efforts to reduce demand, i.e. treatment.

"The availability of treatment gives the drug user, who finds drugs becoming scarce and expensive, an alternative," notes the paper. The two efforts go hand in hand.

"Increases in the resources devoted to one activity will be most effective only if increased resources are simultaneously devoted to the other."

Although these two activities are currently balanced in terms of funds — the federal government here spends annually about $350 million in attempts to reduce supply and a like amount in treatment programs — those concerned about the problem are relieved that this paper affirms the need for treatment: Drug abuse control is not a subject of current major public concern, thus equally, it is not a major concern to a pragmatically oriented administration as is President Ford's.

Ford 'containment' begins

Meanwhile the drug abuse problem, far from having turned the corner, as former President Nixon maintained in 1972, is bigger than ever.

After a downturn in the early 1970's, heroin use has gone back up: There are an estimated 500,000 untreated heroin addicts. Another 500,000 are multiple drug users — a classification that in the paper is used to include those who use drugs other than heroin or alcohol.

Marijuana is now a drug of mass consumption and is being more and more widely used by younger and younger people. The paper estimates that one in five Americans over the age of 11 years — some 25 million to 30 million people, have smoked pot at least once.

The paper does point out, however, that marijuana is a drug that exacts a low social cost, and that the federal government has been de-emphasizing simple possession and use of marijuana in its law enforcement efforts in recent years.

Few people today are arrested solely for possessing and using this drug. Those who are charged are normally also being charged with some other more serious offence as well.

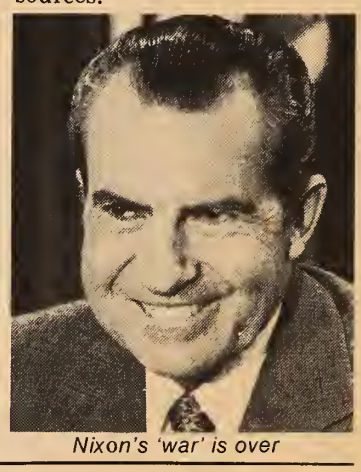
Six American states have recently decriminalized the possession of small amounts of marijuana and most of the others have downgraded possession from a felony charge to a misdemeanor. While all these moves are regarded by the authors of the White Paper as desirable, if only because prosecuting marijuana users was tying up valuable resources, nevertheless, states the paper: "Vigorous federal law enforcement aimed at the major traffickers in marijuana should still continue."

Against this somewhat more relaxed attitude toward marijuana, however, must be set the opinions of those, such as Dr Robert DuPont, director of the National Institute on Drug Abuse, who feel that merely shrugging one's shoulders at the popularity of marijuana is not good enough. It simply opens the door to the use of other drugs of mass consumption such as alcohol and tobacco, they feel.

Along with these strategies, the White Paper devotes some attention to the management of the nation's drug abuse program. There is a need to improve the efficiency and effectiveness with which the program is managed, the paper observes. It notes that efficient management tended to be forgotten when the drug abuse program was in its rapid growth. Now that the program and the agencies running it have matured, it is time to strengthen the management.

Along with this, there is some discussion of the drug program's proper place in the federal bureaucracy. Direct White House involvement should be restricted and management at the cabinet level strengthened, the paper states. (The significance of this for the agencies involved is discussed in the accompanying article.)

The paper concludes its recommendations with a bold affirmation: "Significant progress can be made without requiring the commitment of substantial additional resources."



Nixon's 'war' is over

US must make effort abroad

MIAMI BEACH — Firm measures must be taken to demonstrate to the international community that drug abuse is not *only* an American problem.

In an address to the first national forum on drugs, alcohol and women, Peter Rodino Jr., chairman of the US House of Representatives Committee on the Judiciary, said action is urgently needed to convince foreign countries that the American people are totally committed to eliminating the scourge of drug abuse.

Mr Rodino reminded his audience that the actions, or more accurately the inaction, of other countries can greatly influence both the scope and usage patterns of the drug problem in the United States.

Mr Rodino, who has maintained that every effort must be made to cut off the supply of "hard" drugs at the source, pointed to the result of Turkey's ban on the cultivation of poppies in 1972 as a sample of potential success.

But, while Turkish poppies were the source for almost 80% of heroin reaching the US in 1971, recent figures from the federal Drug Enforcement Administration indicate that 83% of heroin seized in New York and Philadelphia in the last six months originated in Mexico.

"This phenomenon is a clear indication of the urgent need for close international cooperation, and it is imperative that our government — both the Administration and the Congress — exert intense and persistent pressure on those countries which fail to cooperate with us in our efforts to attack the drug problem."

While his particular work has focussed on law enforcement efforts, Mr Rodino is mindful that a comprehensive approach is required; one that takes into account the need to eliminate supply of drugs and disrupt the distribution system, enforce criminal laws strictly against drug traffickers and pushers, treat the drug abuser, and educate the citizenry against illicit drug use.

Mr Rodino expressed his conern that the US government may be rapidly losing the war on drug abuse.

"I am deeply troubled by the thought that the drug abuse situation in America today may be far more serious than during the peak years of 1970 and 1971."

However, he expressed optimism that the recent study of the government's Domestic Council — which produced its White Paper on Drug Abuse — "will once again focus federal resources and public attention on this serious problem".

Heroin users— 10% become adddicts

WASHINGTON — It is no longer accurate to see drug use as an inevitable process from experimentation to addiction, according to Dr Robert L DuPont, director of the National Institute on Drug Abuse.

He was speaking on the release by the agency of four new studies involving more than 20,000 people and done over a 12-month period. Participants in the studies included householders, high school students, Vietnam veterans and men registered with the selective service.

The studies found that only about 10% of heroin users become addicts: Seventy per cent of the Vietnam veterans who returned to the US in 1971 addicted to the drug, were no longer addicted in 1974 although 80% of them said they still used the drug occasionally.

Dr DuPont said the four surveys "clearly show separate and distinct patterns of drug use — experimentation, occasional use, regular use, and heavy use". The pattern is applicable to heroin as well as to marijuana, he said.

The studies also show use of marijuana, alcohol, and tobacco peaks in 18- to 20-year-olds. Marijuana users begin to taper off use in their mid-30s and those who use alcohol or tobacco tend to decrease use in their mid-40s.

The studies show an increase in use of all types of drugs, including alcohol, among young teenagers. One out of every five 13-year-olds tried alcohol and between 1972 and 1974, 14- to 15-year-olds more than doubled their use of marijuana. Use of marijuana by 12- to 17-year-olds rose by only three per cent in the same period.

Six per cent of America's three million high school seniors smoked marijuana daily last year and at least 50% tried it. It was more popular than tobacco.

Alberta study concludes:

Drunk driving behind rising death toll

By WALTER NAGEL

EDMONTON — Alcohol and mood-altering drugs predictably receive major blame for Alberta's increasing traffic death toll, in a special study just released here by the provincial government.

A year-and-a-half in preparation by an 11-member task force which included doctors, lawyers, government officials and two internationally recognized authorities on traffic safety, the report says it is time to curtail impaired driving with the imposition of more highway checks and severe penalties for infractions.

More than 500 people were killed because of alcohol-caused traffic accidents in Alberta during the years 1970, 1971, and 1972 — a study period which forms the prime focus for much of the commentary in the report.

The document says drinking was at least a significant factor in well over half of fatalities which were investigated, and that traffic collisions were the single most prevalent cause of death among persons younger than 35 in this province.

Commissioned by the provincial government, the report urges a stiffening of the current Check Stop program in Alberta, which has been in effect for several years.

Wolfgang Schmidt

Roy McMurtry

P. J. Farmer

The legislation permits police to stop groups of cars at random on highways or in urban areas, to check for obvious impairment and to ensure that vehicles are properly licensed and insured. Although there has been no dramatic increase in numbers of people charged with drunk driving, police — and many motorists — say the number of persons driving after drinking has declined as a result of the program.

The report urges a tougher attitude toward those convicted of impairment. In a critical comment, it notes that the current first-offence penalty is usually a $150 fine, even though there is provision for a maximum $500 fine and three months in jail.

Even second offences are seldom prosecuted as such, and therefore there is little chance that guilty persons receive the mandatory jail term prescribed for repetition.

"A new and drastic approach," is recommended, providing for seizure of a motor vehicle if the owner is guilty of driving while under suspension after an impairment conviction.

Fines are not effective penalties, and they vary as a deterrent punishment because some people can pay them much more easily than can others, the report notes.

"No facet of existing legislation is more in need of rigid enforcement than the imposition of prolonged suspension, a jail term, rehabilitation or more innovative deterrents for individuals driving while suspended, and for recidivism."

The report urges blood testing of all accident victims and drivers involved in fatal accidents, to check for possible involvement of prescription medications or street drugs. Warnings about excessive drinking should be displayed in licensed premises, and there is a recommendation that breathalyzer units be experimentally installed in bars.

Other suggestions include compulsory driver re-examination every five years, or completion of a defensive driving course as an alternative. Graduation from such a course would be demanded before issuance of an initial licence, and every first licence would be probationary for two years. There would be emphasis, and government support, for driver training programs in the schools.

Although vehicle defects are considered solely responsible for only a few fatalities, annual inspections would cover at least brakes, lights, steering and tires, the report recommends.

Excessive speed is second only to impairment as a cause of traffic fatalities in Alberta, says the study, urging reduction of the current 60 mph limit to 55.

Mandatory re-examination and testing of drivers should begin at 65 years of age instead of the current 70. On the other end of the age scale, the report shows that during the 1970-72 period, 42.8 % of traffic deaths involved drivers of 15 to 24 years. Speeding, losing control and leaving the roadway, and impairment, were cited as the main causes.

Almost 400 pages in length, the two-inch-thick report declares that "most" Alberta motorists are gravely deficient in driving attitudes and skills, It emphasizes that vehicles become lethal weapons in the hands of such persons.

The Alberta Safety Council, in a submission to the study, concluded about 10% of the province's one million licensed drivers are involved in reportable traffic accidents every year, and about 10% more have minor collisions which need not be reported to authorities.

Lifetime bans proposed

(Continued from page 1)

would involve a change in Canada's Criminal Code and federal justice minister Ron Basford has indicated his willingness to grant judges the power to impose lifetime driving bans . . . if all provinces agreed to such a move.

(A Canadian judge now has the power to suspend a driving licence for up to three years).

Ontario's attorney general said he opposes proposed change in the Criminal Code that would prevent judges from imposing driving prohibitions as part of sentences.

At present, the federal law provides a minimum fine of $50 and a maximum of $500 and three months in jail for a first impaired driving conviction.

A second conviction brings a minimum of 14 days in jail and a third, three months.

In addition, under the provincial Highway Traffic Act, an impaired driver's licence is automatically suspended for three months for a first offence and six months for second and subsequence offences.

Because of the differing federal and provincial penalties, some judges are granting drinking drivers the right to drive under the federal law although the provincial law automatically suspends their licences.

The federal government proposes, through the Criminal Code, to make penalties uniform.

But instead of preventing judges from imposing prohibitions, Mr McMurtry said judges should be given the power to grant longer driving suspensions.

In the wake of Mr McMurtry's stated intentions, a spokesman of the Addiction Research Foundation of Ontario was quick to point out that the attorney general's plan would do little to reduce road deaths because few impaired drivers involved in accidents are repeaters.

Dr Wolfgang Schmidt, ARF associate research director, reported that no more than five percent of impaired drivers involved in accidents in any given year are repeat offenders.

"The largest damage comes from the larger group of first offenders," Dr Schmidt noted.

Schmidt, an epidemiologist, said only random roadside screening of drivers — "without any indication of wrongdoing" — will reduce fatal road accidents.

Dr Schmidt said a simple device already on the market and in use in many countries determines immediately if a driver has been drinking.

The device, a tube into which the driver blows, registers an immediate color change if the driver has consumed alcohol.

Heavier penalties for drinking drivers were also urged recently by P. J. Farmer, executive director of the Canadian Safety Council.

In an address to the Canadian Foundation on Alcohol and Drug Dependencies in Quebec City, Mr Farmer said the 0.08% blood alcohol level at which drivers now are charged should be reduced to 0.05%.

In addition, police should be allowed to conduct breathalyzer tests at the roadside, Mr Farmer said.

He would also like to see fines related to earnings, an increased use of jail sentences, and stiffer penalties for driving while a licence is under suspension.

Mr Farmer also called for amendments to the law which would allow courts to order treatment for those who require it.

Dope-testing is overplayed

(Continued from page 1)

dope-testing is a deterrent because we did tests and we stopped 75 athletes from taking drugs, but there is no such real objective evidence."

Calling for a reappraisal of costly procedures, Dr Hanley insisted that talking about dope tests over a period of time is talking about millions of dollars.

"I am not saying that Montreal is spending that much, but one should question in an over-all way if this money could not be better expended."

Dr Hanley said the two most looked for drugs — ephedrine and amphetamine — are the "most dangerous" but concern should also be shown for the fact that modern test procedures can demonstrate the presence of a minute quantity of a drug, he said.

He referred to the recent case of the Canadian girl (Joan Wenzel) at the Pan-Am Games in whom traces of ephedrine were found. The drug had been in an anticongestant pill taken 18 hours prior.

"Was that doping?" he asked.

Present tests can detect the presence or absence of a drug without reference to concentration, he added.

Dr Hanley, college physician at Bowdoin College, Brunswick, Maine, thought there might be a better way to control the taking of stimulants or depressants by athletes.

"There is no drug that supercharges the normal cell — never has been — and we should think of educating the young to this basic fact."

Admitting that the drugs may have a strong psychological effect, he countered with the statement that the placebo effect has been with us throughout the history of sports medicine.

"Belief in the magic potion that would improve performance is older than the Olympics. The Chinese started it with the ginseng root."

He said he has been through the literature and press reports and has worked with athletes for over 30 years and just about every conceivable substance has been used.

Youthful drinking drivers

More research urged

LONDON, ONT. — Scientists must find new relationships between young drivers' involvement in traffic accidents and their abuse of alcohol and other drugs, Paul C. Whitehead told the annual conference in Vancouver of the Canada Safety Council.

Dr Whitehead, an associate professor of sociology at the University of Western Ontario and an Addiction Research Foundation of Ontario consultant, said there is still little known about when, where, and how much young people drink or use drugs and then drive.

He said young drivers have higher than normal collision rates independently of alcohol and other drugs, and with them the problem is worsened.

Since the lowering of the drinking age, four times as many accidents have been caused by drunken 18-year-olds in London, he said.

Unless political and social changes are made, Dr Whitehead said the future will be bleaker as young people become more affluent, comprise a larger portion of the vote, and accept the use of legal and illegal drugs more readily.

"Social factors, rather than driving experience, condition of the vehicle, or reporting practices, account for most of the excessive rates of collision among young drivers," he said.

Males between the ages of 15 and 24 are increasingly involved in collisions, homicides and suicides. But Dr Whitehead says the particular life events of 18- and 19-year-old men account for most collisions — "graduating from school, moving away from home, deciding about employment and, for Americans in the past, the draft."

Young drivers generally do not have as much alcohol in their blood as older drivers who are in collisions. However, Dr Whitehead says, inexperience in both drinking and driving is not a major factor in traffic accidents involving young people. The relative importance of learning to drink and drive must be investigated more though, he says.

There has not been enough assessment of the effects of marijuana, barbiturates, tranquillizers, and multi-drug use in real driving situations. Further research "should involve large samples of collisions where drivers are tested for recent use of drugs".

Young people drive more often under the influence of marijuana (sometimes in combination with alcohol and other drugs) than older people. But worse impairment and more collisions result from use by adults of legal drugs, he says.

MILAN KORCOK reports from the annual meeting of the American Society of Criminology, held in Toronto.

No panacea in sight

TORONTO — Development of a treatment strategy for narcotic addiction should go beyond the touting of one technique to the exclusion of all others, according to Dr Wilfred Boothroyd, acting director of the Addiction Research Foundation.

Wilfred Boothroyd

In an address to the annual meeting of the American Society of Criminology, Dr Boothroyd said too much damage to the treatment effort has already been done by characterizing certain treatment as "the only way", by hoping that one mechanism could become the treatment of choice for all people.

"Many addicts are shifting freely one drug to another, depending on availability. What may be sound treatment for abuse of one of these chemicals, may be totally impractical or even dangerous to someone abusing another," he said.

"Given the rapidly changing nature of drug abuse, flexibility is probably the most important component we can retain in our treatment programs."

Methadone maintenance has been an effective treatment modality, heroin has also been used successfully in some maintenance situations, but neither of these should be considered a panacea, he suggested.

"When we seek rational perspectives toward heroin it means more than (arguing about) the pros and cons of methadone, or the replacement of this mode of treatment with free heroin, or the provision of financial support for therapeutic communities.

"We must also explore the validity of antagonists, and medical services, and the rehabilitative services that already exist in our communities.

Referring to a plea made at the conference to free up heroin as an alternative to methadone, Dr Boothroyd admitted that "for a few people (heroin) may in fact be the treatment of choice."

But he also noted that in Britain, where heroin has long been available in therapeutic situations, many patients and their physicians are turning away from heroin clinics and toward methadone. (This is not the traditional high-dose mode of treatment, but low dose, short term use, with an eye toward a drug-free state.)

On the other hand, evidence in parts of North America indicates that methadone is losing considerable appeal as a form of therapy.

ARF experience with methadone maintenance and withdrawal programs shows a lessening of acceptance by many patients of high dose methadone.

Bureau of Dangerous Drugs data also indicate 22% fewer people receiving methadone in Canada in the summer of 1974 than in the summer of 1973, and even fewer at the beginning of 1975.

Certainly methadone maintenance has been a valuable component in our therapeutic response, said Dr Boothroyd. "But we delude ourselves if we think it is the only way, or even the best way for all addicts.

"Those of us in the field have been too quick to approach drug problems from positions of vested interest. I refer not only to differences between health personnel, enforcement officers, legislators, and social workers, but to the distinctions within our various disciplines.

"The friction that has resulted from this insularity has been destructive."

Methadone - from clinic to street

TORONTO — If the diversion of methadone from "legal" clinic use to "illegal" street trading ever becomes recognized as a serious social problem, controlling it will be every bit as difficult as trying to control heroin use.

In an address to the annual meeting of the American Society of Criminology, John Martin, sociologist at Fordham University, added that the large scale establishment of methadone maintenance clinics has been instrumental in increasing the supply of illegal narcotics on the street.

"Illegal methadone, now widely used by addicts, rivals heroin as to its reported availability," he said. "Diversion from methadone clinics is one of their most notable characteristics."

Martin told the assembled criminologists that at the present time, 7.5 million doses of methadone are being distributed annually by government licensed clinics.

He said that in 1966 there was a single experimental methadone program in New York. By 1975, there were more than 30,000 patients in New York City alone and an estimated 80,000 nationally.

"Indeed, so extensive is the present use of methadone maintenance on a national scale that it is extremely difficult to list either the programs or very accurately estimate the number of patients in treatment."

Referring to data from a series of Fordham studies on availability of street methadone (done first in 1972 and then updated in 1975), Martin noted a vast increase in diversion of methadone from clinics.

In 1972, 19% of non-patient, street addicts surveyed in five US cities, reported having used illegal methadone during the previous week. By 1975, 46% had reported such illegal use in the week prior to the survey.

In Philadelphia, 92% of the subjects surveyed in 1975 claimed to have bought or used illegal methadone at some time. As well, 38% of addicts surveyed claimed they used the methadone to get high.

In 1975, 72% of the addicts surveyed claimed that illegal methadone was readily available in their cities, compared to 86% who said heroin was readily available. Furthermore, 92% of respondents cited patients already in methadone clinics as being the most common sources of illicit methadone.

Because of the diffuse nature of the methadone trade, controls would be particularly difficult to implement, said Martin.

"The distribution system of illegal methadone, which largely involves patients, is so ubiquitous and decentralized that the standard bust and buy arrest procedures used by police against heroin and cocaine traffic would be ineffective."

Federal and state courts and correctional agencies are now so overtaxed they could not easily absorb the large numbers of cases which would result from widespread arrest of low-volume buyers and sellers of street methadone, said Martin.

He added that even if the diversion of methadone from the clinic to the street could be reduced by police action or other means, there is such high demand for this drug that one would expect organized, sophisticated distribution systems to develop to fill the persistant need.

Martin emphasized that during the past decade, national emphasis in treatment of drug addicts has focussed primarily on treatment rather than imprisonment. This has effectively eroded the dominance of the law enforcement policy which previously prevailed.

He suggested criticism of the evolution of "special interest groups" at national, state, and local levels into a "drug treatment industry" which has developed "considerable skill in advancing and protecting its interests vis-a-vis those of the drug control industry."

During this evolution, law enforcement policy has changed so as to emphasize intervention at the middle and upper levels of the highly organized heroin and cocaine distribution systems.

This has left an enforcement void at street level, which is where most of the methadone action is concentrated.

Given this set of circumstances, it is unlikely the illegal buying, selling, and use of methadone can easily be controlled "even if the phenomenon should be widely defined as a serious social problem;" Martin warned.

Legal heroin advocated

(continued from page 1)

Trebach recommended that changes in federal law be enacted to allow states local option in deciding how to handle the control and distribution of the drug.

"Many responsible people equate the very thought of legalizing heroin with legalizing the devil — or sin.

"Our greatest task, therefore, is to convince decision makers that we are rational social architects seeking objective data on the possible consequences of a drug, and not the devil, available to certain people under the care of a doctor."

Trebach said that under a local option plan, any doctor would be allowed to apply for a licence to prescribe heroin to non-addicts, and each county government, in consultation with medical, legal, and law enforcement associations, would be allowed to set up a system of clinics supplemented by private physicians to deal with addicts.

Addicts should be authorized and encouraged by the law to seek medical treatment, and doctors should be trained to treat them, prescribing pure heroin in appropriate cases, said Trebach.

Maintenance of addicts, on heroin, by physicians, over a period of years would thus be completely legal.

In making these recommendations, Trebach said it would be a mistake to follow the British system of restricting treatment of addicts to government-controlled clinics, as many would never enter the door of a government establishment for fear of exposure.

But he does believe a combined system of clinics and private physicians would attract a much larger proportion of untreated addicts to get the help they need.

The prospect of heroin as a legal drug traditionally raises fears that its use would spread, and vast numbers of young people would be rescruited to addiction.

This need not be the case, said Trebach, though there is a possibility some young people might be able to obtain legal heroin from a physician by feigning addiction. This may happen in some cases, but not many. It would involve considerable effort by the young person and the chances of his getting away with this kind of lying for long would not be too great.

"The danger of some young people obtaining heroin from doctors by feigning addiction under a new system, must be weighed against the existing dangers, which mean that many youths today can buy heroin in the shadow of the White House — without having to convince a doctor of anything."

Perhaps the greatest advantage of legalized heroin would be its effect on criminal activity, which Trebach believes would be sharply reduced.

Addicts entering methadone treatment usually show a dramatic decrease in criminal activity. There is no reason this should not be the case among addicts entering legalized heroin treatment, he says.

Peter Bourne

VALUE SYSTEM CRUMBLING EXPERT SAYS

FORT SAN, SASK — A breakdown of our social value system is responsible for the increase in alcohol abuse which continues to sweep North America, according to a leading United States expert.

In a keynote address at a Community Action on Alcohol Conference here, Dr Peter Bourne, consultant to the Washington DC Drug Abuse Council, pointed out that built-in safeguards such as high prices, condemnation and punishment for heavy drinking are no longer available.

Historically, alcohol was regarded as universally unwholesome and the relatively high cost helped curb its use, Dr Bourne told delegates.

But today, there is a progressive breakdown of the social support systems which clearly defined earlier use of alcohol.

"Families no longer learn and practice moderate drinking in the home; young people spend most of their leisure time with their peers and give in to peer pressure," Dr Bourne said.

"The frustration of living a fast-paced existence, with intense demands and pressures, makes people turn to alcohol as an 'out'. Uncontrolled drinking, leading to alcoholism, is a by-product of loneliness and lack of recreational activity."

Dr Bourne noted that broken marriages, job competition and a lack of faith in traditional helping resources, such as the church, combine to make depression the most common affliction of our society.

"Alcohol was once an integral part of a stable social system, carrying no special symbolism," he said. "We have redefined the role of alcohol in society, it becomes a sign of maturity to drink, an accepted way to unwind.

"People must learn to deal effectively with the stress and frustration prevalent in society."

Only when the entire community is made aware of the need for change, will society be able to eliminate the problems, he said.

(More from the Community Action on Alcohol Conference in the next issue of The Journal)

Women on brink of recognition

Gary Seidler reports from the first National Forum on Drugs, Alcoholism and Women held in Miami Beach

MIAMI BEACH — The National Institute on Drug Abuse appears fully committed to developing knowledge and awareness of the plight facing women in the addictions field.

The federal agency is particularly interested in factors that play a role at various transition points in people's lives, NIDA director Dr Robert DuPont assured participants at the National Forum on Drugs, Alcoholism and Women.

"For certain groups," said Dr DuPont, "specific points of their lives appear to produce the likelihood of becoming more drug involved. We will be looking at such critical influence in the lives of women that may influence their drug use."

Dr DuPont noted a national collaborative project initiated to identify the special treatment and service needs of female drug abusers, evaluate the effectiveness of existing health delivery systems in treating female drug abusers, and develop new and potentially more effective treatment models more sensitive to the special needs of women.

"The most important part of this project is that women are involved in determining the issues; women are involved in addressing the issues; and for the first time women have an opportunity to have an important impact on the drug treatment field at the national level," Dr DuPont said.

The NIDA collaborative project is focussing those issues, concerns and needs believed to be most important to the female community.

Dr DuPont listed these as: —

- the female addict and her child (motherhood and its implications for treatment;
- societal/attitudinal factors (sexuality, femininity, female self-concept, female role and function, sex role, stereotypes, societal factors);
- medical treatment and complications (the treatment of chronic medical problems, the methadone mother and her child, preventive medical practices);
- employment and education (special problems of women addicts and employment, female occupations, career aspirations and sex roles, self-realization and reality . . .);
- legal problems (child placement, alternatives to incarceration, sentencing patterns, differences in the legal response);
- the nature and extent of drug use in female populations.

Dr DuPont emphasized the serious attention NIDA is placing on the potential hazards of drugs of abuse to women's health and that of their possible children.

"It is important that possible genetic or other effects on fetal development be adequately explored.

"For example, the pregnant woman on methadone is very much concerned about the possible effect of the treatment she is receiving on the health of her baby.

"Moreover, she is frequently concerned about her adequacy as a mother and about the possibility that her newborn will be taken from her by governmental authorities.

"She very much needs the help of understanding social workers and other treatment staff if she is to escape the addiction cycle and be successfully rehabilitated."

Dr DuPont said treatment and rehabilitation of women drug abusers must be flexible enough to offer a range of choices.

"While many women may choose traditional life patterns, others may wish to follow less traditional vocational or life paths.

"This should be their choice, based on their values and aspirations and not one imposed by the inflexibility of treatment arragements or preconceived ideas of what a woman's role should be."

Era of double standards is passing

THE DRUG ABUSE prevention field needs to focus attention on the problems of women because there are many signals — sometimes obscured and fragmented, often clear and direct — which point to an increased "parity" of problems with men.

This parity is not reflected in the institutionalized activities of the field, Dr Robert DuPont, director of the National Institute on Drug Abuse, told the national forum.

"Only now is there an admission of the scope of female drug abuse and a willingness to probe its complexity and scale."

Dr DuPont said that in the past, women were generally regarded as delicate, innocent and incorruptible. Cases of addiction were ignored, excused or covered up.

"In addition, and speaking to the present as well as the past, women's traditional roles frequently enabled them to better disguise their drug problems and effectively served to prevent their seeking help until their problems were severe.

"Even today, the woman occupying the traditional and often isolated role of homemaker, for example, can develop a serious alcohol/drug problem that goes undetected by others for some time.

"The work performance of traditionally employed men, by contrast, is far more likely to be subject to the scrutiny of others and subject to more explicit standards of performance."

Dr DuPont drew attention to the larger numbers of women for whom the job of fulltime homemaker is no longer appealing but who do not have ready means of again becoming satisfyingly engaged outside the home.

With th e decline in large families and greater opportunity to choose the number of children she will bear, a woman has many more years of useful and productive life outside the home, Dr DuPont said.

Current drug taking habits reflect the general conclusion that the era of the double standard for men and women is passing as the pressures of modern life begin to affect both sexes similarly.

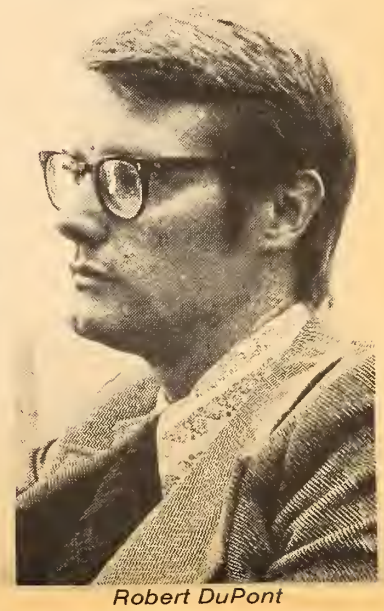
Dr DuPont presented various statistics which reflected this equality with respect to drug taking habits:-

- Among adults over 18 years almost twice as many men have used marijuana. But among adolescents, nearly equal numbers of boys and girls are using the drug;
- Some recent surveys of drug use indicate that for some drugs, use by women exceeds that by men. For example, cigarette smoking by girls consistently increases while smoking habits of boys decreases;
- Teenage girls are accelerating their use of alcohol and in the last five years greater increases in regular drinking have been reported among girls than boys;
- Twice as many women as men have used the two most popular minor tranquillizers, diazepam and chlordiazepoxide (Valium and Librium);
- Fifty percent more women than men report ever using barbiturates for medicinal purposes. Three times as many women as men report ever using amphetamines for a medical purpose;
- The percentage of women who use "pills" to cope with stress has increased almost 30% from 1972 to 1974. Among males, there was no similar increase.

Dr DuPont pointed out that statistical accounts do not begin to capture human implications as, for example, women have borne the burden of drug abuse of family — usually male — members.

He said the cost of supporting a drug habit has played a significant role in encouraging criminality on the part of addicted women.

The woman heroin addict, he continued, has a triple handicap for she is typically poor, addicted and a woman.



Robert DuPont

"But the added disabilities of being a woman and a drug abuser are by no means limited to the woman addict with her typical pattern of being sexually exploited and otherwise discriminated against.

"There are many forces that encourage escapism through drugs for women in all walks of life whether they are rich or poor, of minority status or members of more advantaged ethnic or racial groups.

"And there are many ways in which subtle and not-so-subtle discrimination play a part on women's drug problems."

Alcohol, tobacco use by women sure to increase: statistician

USE OF ALCOHOL and tobacco by women will likely increase significantly over the next 10 years, warns a Californian biostatistician.

Unless there are unforseen changes in current trends, a much greater number of women will develop the kinds of problems associated with these drugs, Lilian Blackford, of the San Mateo County Department of public Health and Welfare, told the conference.

Ms Blackford's conclusion results from an eight-year study of the alcohol and other drug habits of high school students in San Mateo County, frequently regarded as a bellweather of national trends.

While information on levels of alcohol and tobacco use by females is generally sketchy and fragmented, Ms Backford claims the continuing San Mateo study has sufficient bearing to predict what can be expected in 10 or 15 years, particularly for upper middle-class women.

San Mateo County has one of the highest median family incomes in the United States, plus high educational levels and expensive housing.

For the teenager, this means more than average spending money, access to an automobile, and the kind of cooking that starts with the opening of a bottle of wine, Ms Blackford said.

The speaker presented data which reflected sharply rising trends for those reporting drinking on 10 or more occassions during a year.

The rate for Grade 11 females more than doubled from 1968 (24.9%) to 1975 (54.5%). Rates for male students increased from 35.6% to 62.4%.

At the same time, Ms Blackford reported, gardeners and janitors on school campuses note a great increase in the number of discarded empty bottles (tequilla, vodka, sweet wines) and cans (beer, ale and sweet mixes for vodka) since 1968.

The prediction of future problem drinking patterns for women is based on the idea that a person who uses a substance to the point where there are problems for that person, or the surrounding environment, is assumed to be in a chronic disease process.

"Different people have different susceptibilities," Ms Blackford said. "If any use of alcohol is encouraged for a larger proportion of people and/or at an earlier age, it tends to affect a larger number in the very near future.

"As these affected people age, they accumulate in the total population and the total number of people with prob lems builds up greatly year by year.

"The fact that exposure to alcohol has almost doubled over the teen years and that it begins earlier in each (San Mateo) study, would indicate that much larger numbers — possibly twice as many — are feeding into the population of potential adult female problem drinkers in 1975 as were feeding into it in 1968.

As for tobacco-use, while rates among males have decreased since 1971, rates among females have increased steadily.

Ms Blackford told the conference that while money is allocated to various programs designed to combat substance abuse, the programs are generally provided for males, and there exists an appalling lack of even simple data on the extent of problems among women.

"If some effort is not made to show the extent of the problem, and what proportion are women, it is unlikely that any adequate educational and treatment program will exist," she concluded.

MDs' prescription habits similar for both sexes

THERE IS no evidence to support the contention that physicians more often prescribe psychoactive drugs for women patients with psychological symptoms than they do for men with similar symptoms, according to Dr Robert DuPont, director of the National Institute on Drug Abuse.

Although NIDA's own national survey data show that a significantly larger percentage of women use prescribed psychoactive drugs, Dr DuPont suggested further analysis is required before jumping to the general conclusion that physicians push women, particularly, into drug use.

An analysis of frequency of physician visits and symptoms presented shows that "reality proves to be more complex than the simplistic suggestion that women are being over-medicated because of physician bias," Dr DuPont said.

While Dr DuPont conceded that women do typically report higher levels of psychic symptoms than do men, he suggested that with changing sex role expectations we may anticipate that members of both sexes will feel freer to admit to psychic pain and to seek help for it.

"This is not to argue that all prescribing of psychoactive drugs is necessary or appropriate.

"As noted earlier (in the NIDA study), medically prescribed stimulants — the amphetamines — were used by women three times as frequently as by men.

"For some it may be a short step from the use of stimulants for weight reduction to their abuse deriving from their psychological effects."

Drug availability the issue

Overdose deaths are bound to multiply

By JOY-ANN COHEN

LONDON, ONT. — Sociologist Roberta Ferrence's calculations show that in 50 years the number of drug overdoses in London will exceed the community's total population.

"Although it is most likely that rates will level off at some lower point, the message is clear: Providing therapy for even a small proportion of these cases is obviously beyond our human and financial means."

Ms Ferrence, who works at the Lake Erie office of Ontario's Addiction Research Foundation, says decreasing the availability of certain legal drugs is the best way to lower the number of overdose cases.

She tested her ideas through a study of people who injured or killed themselves with drugs. The study was done in London hospitals and community agencies between 1969 and 1971. Similar research in other cities supports limiting drug consumption.

Ms Ferrence says reducing the availability of drugs is a quick, inexpensive, easy-to-evaluate way of controlling many socially undesirable drug activities. Its potential effectiveness has been shown in the prevention of alcoholism.

In London, about one in every 50 people in the total population deliberately or accidentally overdoses each year, said Ms Ferrence. Statistics on self-injury in other communities show annual rates of increase of 10% or more.

"While the proportion of overdoses that result in death is quite small, 3% in our London study, and continues to decline, the actual rates are increasing," she said. This is because the number of people taking overdoses that do not result in death is rising so quickly.

Ms Ferrence chose an environmental control method, limiting drug consumption, partly because she concluded other methods would not work.

She rejects aiming treatment primarily at the social, psychological or physical characteristics of those who overdose with drugs, because it could reach only a small portion of the population.

Roberta Ferrence

She said changes affecting the drug used to overdose "are unlikely to be implemented because they generally involve reducing or eliminating the therapeutic effect of the drug".

Limiting the numbers of certain drugs on the market would cause "a decline in drug-related suicides, in rates of self-injury, in childhood poisonings, in adverse drug reactions, and in medication errors," she said.

Also, less money is spent when fewer drugs are bought and fewer cases of overdose are treated.

Other studies show when people use fewer drugs for medical purposes, the number of drugs used for non-medical purposes also decreases.

Changes in levels of availability and their effects are easily measured, she said.

Ms Ferrence concluded from the London Self-Injury Study: "The proportion of persons who use drugs excessively is related to the total consumption of drugs in society."

She also discovered: "As the level of consumption increases, the proportion of persons consuming at that level decreases."

The statistical pattern of the number of pills taken by those who died from overdoses and those who did not die, supports the idea that the behaviours of the two groups are similar.

Fewer people would be in either group if fewer drugs were available.

Ms Ferrence said London has two female overdose cases for every male case. And women get twice as many drug prescriptions as men.

There is also a remarkable similarity between the types of drugs taken for overdoses and the proportion of sedatives, tranquillizers and analgesics prescribed in the population.

Ms Ferrence recommended: "Many over-the-counter preparations could be available only on prescription; some prescription drugs could be controlled as barbiturates are now."

She would like to eliminate advertising of drugs to the public and promotion to doctors and druggists by manufacturers. She says physicians and consumers should have access to scientific information about drugs.

"The price of non-essential drugs could be raised," she said.

Providing prescription drugs for a low flat fee, as in Saskatchewan, should be reconsidered. "Refunds that are built into the income tax structure constitute a far more equitable measure."

Restrictions and higher prices would apply only to certain types of drugs, so those who need medication and use it in socially approved ways will not be deprived.

"What is considered essential now *could* very well change with the different attitudes that might accompany decreased availability."

Recent restrictions on amphetamine prescriptions, and requirements that physicians who dispense methadone be registered, have led to decreased availability of both drugs. Ms Ferrence says this has not led to greater suffering on the part of patients.

She recommends that "drugs commonly used for overdose should be individually wrapped in foil or cellophane". This is done in Australia, where the per cent of overdoses with analgesics is one tenth that found in London.

To the objection that her suggestions do not get at underlying problems, she said this approach is not meant to replace therapy, but rather to supplement it.

"Since about half of all cases of drug overdose are labelled 'accidental,' it is doubtful such persons would receive therapy in any event."

She said it is unlikely people would resort to more lethal means if the number of drugs available is reduced.

"The rate of suicide for more hazardous methods has remained stable for most age groups even though the rate of drug ingestion has increased rapidly in recent years."

Psychotropic drugs

Side effects need curbing

MONTREAL — Are side effects of psychotropic drugs the price we have to pay for getting well?

Yes, to some extent, but preventive measures would reduce that price, according to the senior psychiatric researcher at St. Mary's Hospital here.

Such preventive measures would be prior knowledge of side effects, prompt recognition and quick remedial action, Dr Jambur Ananth told the annual meeting here of the Quebec Psychiatric Association. Dr Anath is associate professor of psychiatry, McGill University.

In a study of 52 patients over a 2-month period, he noted 348 adverse reactions to psychotropic drugs.

"Even though psychotropic drugs are generally safe, because of their non-specific and multiple action, they produce side effects. In fact, *all* patients admitted to our monitoring program manifested adverse reactions, although this 100% occurrence is slightly higher than shown by other published studies."

This variation might be accounted for, he said, by the St. Mary's researchers' definition of adverse reaction which included any action other than the intended reaction, and possibly more precise monitoring.

"Not only is the incidence of adverse reactions high, *many do not dissipate*. Therefore, it is likely that many patients discontinue medication not because of poor motivation but because of difficulties attributable to side effects."

His study, with research associate Dan Foster, a medical student, aimed at ascertaining the number of side effects and their sequence; a differentiation of time-related and dose-related side effects as well as those that dissipate and those that need counteractive measures; the number and nature of side effects at discharge and the significance of ethnic differences in their occurrence. Not all data has been collated, so a complete report was not given to the QPA meeting.

Pot-smoking youth typically convivial

By MARY HAGER

SAN FRANCISCO, CAL. — The typical, middle-class teenaged marijuana user is convivial, likes parties, and is an average or better student who expects to graduate from high school.

This is the finding of a study by the New York State Drug Abuse Control Commission of 246 marijuana users among 618 seventh through twelfth graders in a suburban high school.

In a report to the recent American Sociological Association meeting, Professor Richard Dembo, said the students were not anti-social and did not regard their marijuana use as "problem behavior".

Instead, they seemed to have "replaced conventional beliefs and pursuits with a commitment to a peer centred culture, valuing conviviality and an openness to a quest for new experiences, including the use of various substances," said Prof. Dembo, a sociologist with the commission.

Marijuana seemed to be part of an "expressive life style". Users were frequent participants at parties and dances and the "marijuana-using youths in our study were more convivial than students taking this substance infrequently or not at all," he said.

The users had "learned from friends" and all but 2% had friends who were also users. Fifty-three per cent of the non-users had friends who were users.

The marijuana-using students were more apt to have experimented with other substances, but poly-drug use was not common among the high school students who used marijuana frequently, Dembo said.

Not surprisingly, the marijuana users felt drug use is a personal matter and should be decriminalized. They did not, Dembo said, believe the drug problem would be solved by tougher law enforcement, more and better education, making school more interesting, improving communication between parents, students and schools, or helping people to understand better themselves and their problems.

While there was a tendency for users to be "disengaged" from their families and more oriented to their peers, the factors of rebellion and anti-social or deviant behavior associated with earlier marijuana use, were not present, he said.

Nor, he stressed, could it be demonstrated that users were disinterested in school. A majority of users maintained average or better grades and 95% said they expected to graduate from high school, he reported.

Alcohol counsellors join runaway centres

By David Woods

NIAGARA FALLS, NY — Of the 100 runaway centres in the United States, 16 now have federally-funded full-time counsellors to deal with one of the major reasons young people run away from home — their own or their parents' drinking problems.

Tom McCarthy, director of the National Youth Alternatives Project (NYAP) runaway and alcohol program, told **The Journal** the NIAAA funding amounts to $300,000 a year for three years.

The alcohol counsellors, he said are either professionals or "skilled para-professionals", but they try to keep a low profile. To avoid labelling, they assume the role of "an average counsellor", he said.

Young people who demonstrate on their intake forms an alcohol-related problem are matched up with the alcohol counsellor, said Mr McCarthy, and the counsellor "starts to talk with the child about the alcohol issues".

Then, family counselling in alcoholism begins as a part of the overall reconciliation process between parents and child.

"A runaway centre is fortunate in this respect . . . it's able to gain access to the family situation which often cannot be entered otherwise, and we all know that many alcoholic families do a great job of keeping the secret (of their alcoholism).

"We can do some very strong identification work that wouldn't be done otherwise.

"We have leverage . . . we can say 'your child is not going to come back . . . we might be forced to work with the courts and find foster parents . . . unless things change in the family'.

The runaway centres' counsellors are also in the business of what Mr McCarthy calls support work — establishing there's a problem without ascribing wickedness to that problem, offering help and education, referring to Alateen or other community resources.

They also have a "very nuts and bolts, grassroots, person-to-person kind of referral network; you don't refer to someplace because it's the most well-known or the best-established . . . but you refer to individuals at agencies because they know how to work with these kinds of kids".

One major function of the runaway centre alcohol counsellor is to motivate . . . to make a good referral, even if that means sending a child to an agency some distance away from the centre.

At present, the NIAAA-funded runaway and alcohol program is engaged in computer-aided research into the program, which is barely one year old.

As the research is incomplete Mr McCarthy was reluctant to say what percentage of runaways have personal or parental problems with alcohol. He allowed, however, that the percentage is "significant".

Also, because of a lack of community resources for coping with youthful alcohol problems, the runaway centre alcohol counsellors have found themselves increasingly doing work outside the centres, said Mr McCarthy.

"They've become recognized as someone to whom youth can go" in the communities they serve.

Suburban and poor, inner city women share equal alcoholism incidence

ALCOHOLISM IS as prevalent among middle-class suburban pregnant women as it is among their poor, inner city sisters, this audience of rehabilitationists and mother-child health professionals was told here.

The "equally great" incidence of alcoholism in suburban and urban women was described by Dr Henry L. Rosett of Boston University. He said the incidence at Boston City Hospital (poor and urban) is 7%, the same as it turned out to be in a study at Overlook Hospital, in Summit, New Jersey (middle class and suburban).

The Overlook study is important, Dr Rosett said, both for the results, and for the fact of its having been done, since there continues to be resistance to rigorous investigation — for clinical or research purposes — into the drinking histories of middle class, private patients.

The obstetricians do not want to ask their patients, he said. And most hospitals are not interested in finding out either.

Other highlights of the symposium, which was sponsored by the Medical Society of New York County and the city's Addiction Services Agency, included:

* * *

The admonition by internist Dr Stanley E. Gitlow to his medical colleagues to go to AA to learn to diagnose alcoholism and find out what it's all about. Alcoholics are to be found in only two other places, Dr Gitlow added — the barroom and the bedroom.

Women, who tend to be the bedroom drinkers, also tend to drink situationally, rather than steadily, he said, and as a result many are able to decrease their alcohol intake when pregnant.

For the others who do not, he said, therapy is required, with abstinence the only viable goal. Psychotherapy is required, he said, but only *after* they stop drinking. Sedatives must also be foresworn.

"You can't get anything from psychotherapy while (sedatives) are being used," Dr Gitlow said. "The brain simply doesn't mix the two."

With therapy, Dr Gitlow said, "the primary aim is to break isolation," because "I know no unisolated alcoholics.

"Fracture the isolation, and you are on the road to success!"

* * *

Direct questioning, early in pregnancy, is the only way to determine if a woman is an alcoholic, one panelist said, as they may show no stigmata. This prompted the question from the audience of whether alcohol levels ought to be sought in patients' routine blood and urine specimens.

In answering, Dr Enoch Gordis, chief of the alcoholism program at Elmhurst Hospital, in Queens, N.Y., counselled caution.

DAVID ZIMMERMAN reports from a symposium on substance abuse and mother-child health held in New York City

"There's no ready answer," he said.

To do alcohol studies routinely, he said, would raise the question of the patient's right to know what is being done with her specimens.

* * *

"Brain size is the thing most affected in infants of alcoholic mothers," pediatric neurologist Dr Eileen M. Ouellette, of Boston City Hospital, said. Mother's drinking reduces the brain size and Dr Oullette says: "This is very significent."

The safety of Antabuse for the fetus has not been resolved, and the experts were cautious about recommending its use. Dr Rosett said he was "hesitant" to prescribe it, although he said: "Given the choice between Antabuse and alcoholism in a pregnant woman, I'll choose Antabuse."

Dr Gitlow said his practice is not to initiate Antabuse therapy in a pregnant woman. But if she already is on it, he leaves her on it — and thus far has seen no untoward consequences.

JURY STILL OUT ON PREGNANT DRINKERS

WILL IT help the baby if mother stops tippling while pregnant?

This question has come to concern many women intensely, because of recent reports that women who drink heavily tend to deliver babies with congenital malformations, mental retardation and other stigmata.

There is no answer to the question — yet — Dr Henry L. Rosett, a career substance abuse specialist at Boston City Hospital told the conference.

But, Dr Rosett said, a study is underway to find out. The parameters being studied are active sleep, which is like REM sleep, circadian rhythm and related factors, in infants on the third day of life; the third day is assumed to be the first day of normal infant life, following the trauma of birth.

The study is being conducted in collaboration with Dr Louis Sander, who for years had gathered baseline three-day-old neurophysiologic data by placing babies for the day in a special bassinet equipped with a variety of monitoring devices.

Thus far, only a few of the mothers whose drinking traits brought them into the test groups have delivered and the data on their babies is inconclusive.

None that has thus far been tested is the baby of a woman who stopped drinking while pregnant.

"We're eagerly awaiting their being born," said Dr Rosett.

He believes preliminary results that include these women and their babies may be available by spring.

Fetal alcohol syndrome

It's still unpredictable

INVESTIGATORS AT Boston City Hospital consistently find several of the stigmata of fetal alcohol syndrome (FAS) in the offspring of alcoholic women.

But thus far they have not been able to confirm prospectively a consistently increased occurrence of these congenital malformations that they, and other investigators, have found in retrospective studies of malformed infants and their alcoholic mothers.

The teratogenic effects that have been ascribed to heavy alcohol use include microcephaly (small head), micrognathia (small jaw), microphthalmia (small eyes) and cardiac defects.

The Boston study started in May, 1974. Pediatric neurologist Dr Eileen Ouellette told the conference that thus far, 305 randomly selected prenatal care patients have been questioned to determine their drinking habits.

They are young, poor, and poorly nourished inner city women who tend to use alcohol and tobacco, but no other psychoactive drugs.

Thus far, Dr Ouelette said, the mothers have delivered 134 babies. There were no differences in the one and five minute Apgar scores between the infants delivered to abstinent women and those delivered to moderate drinkers and heavy drinkers. Neither did any group of babies show more acquired medical illness than any other.

The infants were classified as abnormal if they had congenital malformations, were jittery, or showed abnormalities of neuromuscular tone.

In the small sample of infants born to heavy drinkers (15 babies), only four, or 27%, were deemed normal, compared to 54% normal for the moderate drinking mothers group and 60% normal in the abstinent mothers group.

"A surprising number of babies in all groups showed hypotonia and/or jitteriness," Dr Ouelette said. "But these signs were much more common in the infants of heavy drinkers."

There were only two babies with serious malformations among the 280 born to abstinent mothers and moderate drinkers, but there were four such serious anomalies among the 15 babies born to heavy drinkers.

Two infants had small heads and one of these also had a small jaw and beak nose. Two others were born with extra fingers or toes (polydactyly).

In Dr Ouellette's view, however, the results thus far fail to demonstrate the existence of a consistent teratogenic effect in the infants of heavy-drinking mothers.

"Except for microcephaly in two patients," she said, "this consistent pattern of malformation has not been found in the 15 offspring of heavy drinking mothers."

Mothers on methadone

'No Nursing' policy is challenged

(continued from page 1)

diazepam, rather than the narcotic withdrawal it was intended to temper.

The "No Nursing" policy that Dr Dole objected to is operative in at least two of the major hospitals in New York City. The director of methadone maintenance at Mt. Sinai Hospital, Dr Barry Stimmel, said in an interview that "in general, we discourage breast feeding of methadone mothers' infants".

The mothers themselves, he said, worry that the methadone may be dangerous.

"So," Dr Stimmel said, "most people advise these patients not to breast feed."

The chief of the neonatal unit at Bronx Municipal Hospital, Dr Stephen Kandall, also disagrees with Dr Dole.

"We usually discourage breast feeding," he said.

The rationale, Dr Kandall explained, is that previously published studies indicate that the amount of methadone in mothers milk is so variable that it cannot be relied upon as an aid in relieving the baby's withdrawal symptoms. So when the baby needs medication for withdrawal, Dr Kandall prefers to use pharmacological agents.

At the newborn nursery at Philadelphia General Hospital, which serves a low-income urban population, pediatrician Dr Loretta P. Finnegan said the issue of breast feeding has not come up. The women simply do not want to breast feed, she said.

But, given Dr Kreek's finding, Dr Finnegan said it might be permissible if a "well-motivated" patient wished to do it.

"Pharmacologically speaking," she added, "it would seem that we could permit breastfeeding."

There was partial agreement from Mt. Sinai's Dr Stimmel. He said Dr Kreek's paper had not yet been published, and has not been corroborated by other investigators. When that happens, he said, "we'll think about" changing Mt. Sinai's policy.

Corrections system causes crime, destroys staff, inmates

MONTREAL — The Canadian and United States correctional systems for juvenile delinquents are "a system for destruction" sustained by tax dollars, two experts in the field charged here recently.

This is true not only for the adolescents it attempts to deal with but also for the staff who work within it, the two maintained.

The speakers were Dr Bruno Cormier, director of McGill University's forensic psychiatry division, and Dr Jerome Miller commissioner of children and youth, department of public welfare, Pennsylvania.

They were addressing a symposium here at Montreal Children's Hospital on psychosocial and ethical aspects of pediatric care.

Dr Cormier said while it is true figures show a statistical relationship between delinquency and poverty," *poverty is not the cause of juvenile delinquency.*

"We must go further as doctors and professional workers and understand there is something more unequal in these children in detention units than in the ordinary poor.

"It is the problem of *human inequality* based upon the destruction of the human potential."

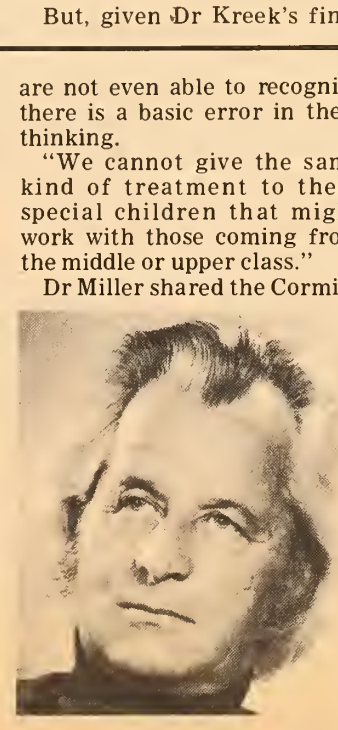
The destruction of that human potential through child beating, for example, leads, in the child, to a lack of sense of self: What happens, he said, is that the child starts life as a non-person, becomes "somebody" through acts of juvenile delinquency, and then is sent to an institution to become again a non-person. This system is generally reserved for the poor and usually is a self-generating continuum on into the adult prison world, he said.

"I've been in the corrections field for 20 years. I know where adolescents were 20 years ago and I know where they are now.

"Those people who build these institutions for juveniles based upon middle-class models are not even able to recognize there is a basic error in their thinking.

"We cannot give the same kind of treatment to these special children that might work with those coming from the middle or upper class."

Dr Miller shared the Cormier view that the characterological defect in most juvenile delinquents stems not just from poverty but from the destruction of that individual's self image.



Bruno Cormier

Unless this fact is recognized, society will go on building juvenile detention centres based on a wrong ideology and that will include such treatment as putting an adolescent in "the hole", he said.

"Those workers who stay within this correctional system for juveniles are eventually destroyed by it. They are destroyed because they cannot help the children within this system."

"The best service concerned professionals can perform is to keep adolescents out of this system because the longer they stay in corrective institutions, the more likely they are to go on to criminal careers."

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DRINKING AND DRIVING

The time is now to shed blinkers

ONTARIO'S Attorney General Roy McMurtry wants judges to have the power to impose lifetime driving bans on motorists with repeated drunk driving convictions.

Good.

But let's not kid ourselves. If McMurtry's intent is to reduce the toll of alcohol-related road injury and death, then locking up the repeater is but a drop in the bucket.

No more than 5% of impaired drivers involved in accidents are repeaters. The vast majority of alcohol-related accidents involve first offenders, and this is the group that must somehow be influenced — before the fact — that there is a real risk of legal consequence if they get behind the wheel after drinking.

When the British imposed their Road Safety Act of 1967 allowing police to screen drivers randomly for the presence of alcohol at the roadside, fatalities in that year plummetted 14.5%. The year following, the reduction in road deaths was 10%, and the year after than 5.7%.

Cynics could argue that the law wasn't working any more, that drinking drivers were just getting back to their old ways. Perhaps, but in the interim, a good many lives were saved and many accidents avoided.

It has been estimated that in a seven-year period since imposition of those laws, some 5,000 road fatalities and 200,000 injuries have been avoided.

There is a lesson in this for Canada.

Authorities agree that the reason the Road Safety Act lost its effectiveness, is that the average Briton could see clearly that it was not being enforced rigorously.

He saw his chances of being picked up as so slim that there really wasn't too much risk in having a few pints before getting behind the wheel.

The whole point of deterrent measures in respect to road safety is that they be felt by the public at large.

"It could happen to me" must be a real and vital concern to each individual driver.

We are not going to gain a great deal, in terms of reducing carnage on our roads by concentrating all our efforts on catching a few fish from a sea of drunken drivers and making horrible examples of them. If we are serious about reducing the toll we must think in broader terms. We're confident that Ontario's new Attorney General realizes this and will follow through.

Let's think about giving police the power to use roadside screening devices on a random basis, of giving enforcement authorities the resources they need to make their presence felt, of allowing them to set up roadblocks and blitz certain high risk areas at their discretion.

Police have their other duties to perform, but special squads could be pulled together for short blitz periods after which the officers could go back to their regular duties.

The public must be brought into contact with the system. The individual must see that the law does work and that his chances of being screened are pretty good. But he must also be aware of the need for this kind of action.

The public should not be allowed to interpret "crackdown" as unfair police measures. The individual really has to believe that it's for his own good.

This is not an easy concept to sell. It would involve particularly imaginative educational programs, directed not only at the mass of drivers generally, but at specific groups — particularly young people.

Since the lowering of the legal drinking age in Ontario, alcohol-related accidents among young drivers have increased out of all proportion when compared to other age groups. In London, Ontario, one recent year, there was more than a 300% increase in alcohol-related collisions among 18- and 19-year-olds.

We face a bleak future if this trend is allowed to accelerate.

McMurtry has already admitted that tougher sentences by themselves won't significantly reduce the gruesome road statistics, that an in-depth education program is necessary if real progress is to be made.

Let's hope that if and when McMurtry's ideas take the form of legislation they are kept in perspective.

The banning of repeat offenders is still a drop in the bucket.

If debate on this issue gives the illusion we're doing more than we actually are, then what have we accomplished? Except that more time will have passed, and more innocent people will have been killed on the roads.

— Milan Korcok

"Spare $13.50 for a bottle of Nuits St. George Drouhin, Sir?"

Letters to the Editor

Sir:

After 40 years of legal recreational drug pushing, there's a revolution going on in the minds of Americans. It is a re-thinking of how to reduce human and economic misery resulting from consumption of beverage alcohol.

What's causing this change is a growing disillusionment with the present "preventative" efforts of major alcoholism groups, government and private. With alcoholism increasing at an alarming rate, even among those in early teens, we have firm indications these so called "preventive" measures just don't work.

Are they failing because some of their members have a vested interest in failure? Alcohol industry officials dominate many alcoholism groups and 80% of their sales are to alcoholics and problem drinkers.

Concerned citizens everywhere are getting fed up with rising rates of alcoholism, increased numbers of alcohol impaired drivers killing and injuring more and more persons, low worker productivity, high job absenteesim, alcohol related rape and murder, broken homes, and higher insurance premiums for health, auto and fire.

As a result, realistic authorities are beginning to turn from trying to live with increased consumption of alcohol to living with less consumption. After years of promoting responsible drinking in moderation as the main preventive measure, present conditions indicate such efforts may be adding to the problem instead of reducing it.

We also need to stop kidding ourselves and come to a new sense of economic reality. The beverage alcohol industry has promoted the advantages of alcohol taxes so long that some Americans fail to realize we are dollars ahead with less consumption, less alcohol taxes, less economic loss. The cost of beverage alcohol comes high — even if you don't drink!

Alcoholics have been viewed as "sick", as suffering from all sorts of mental illness, and prevention has worked on this assumption. But new evidence indicates it is not a "sickness", it is a drug problem. When viewed as a drug problem, preventive efforts take a new direction. Reduced drug dependence comes about through reduced drug use.

Rehabilitation — Help alcohol-dependent persons adjust to life without the drug.

Education— Every person informed of effect of alcohol on mind and body.

Amount — Encourage persons to be non-users and encourage users to use less. As with cigarettes, be proud of I QUIT!

Law — Restrict availabiltiy and places of consumption.

This is the R-E-A-L way to reduce human and economic suffering. Preventive efforts that have proven effective are those aimed at reduced use.

But through powerful alcohol pushing lobbies in every

Backgrounder

By MILAN KORCOK

Understanding Bill S19

FAIRNESS BEFORE the Law is one of those inviolate social objectives that rank with Reverence for Motherhood, and Obedience to the Flag.

You just don't knock it and hope to get elected to the local chamber of commerce, or city council, or national legislature.

Yet the "fairness" that sounds so nice in conceptual terms is not as automatic or as easy to achieve as our primer on social civics tells us, and in the case of certain laws it is downright elusive, if not imaginary.

Exhibit "A" is our cannabis laws, which despite revisions, amendments, and the recommendations of high-powered task forces, remain as hypocritical as ever — a little more humane than they used to be — but hypocritical.

In Canada and the United States, some of this injustice has been recognized and changes are underway, but there is a sneaking suspicion in some circles that political expedience is being more amply served than is the dignity of the law.

An example of this process is the work of Canada's Senate Committee on Legal and Constitutional Affairs, which this fall recommended a series of changes to the federal government's cannabis legislation.

The changes are generally perceived as softening many penalties in respect to cannabis use, and in effect decriminalizing possession for personal use.

Specifically, this committee has recommended an automatic pardon for all people found guilty of a first offence of simple cannabis possession and an absolute or conditional discharge in place of a formal conviction.

So far so good, for proponents of softer marijuana laws.

But all is not what it appears to be.

Certain criminal lawyers looking at the Senate proposals have grown restive since the Senate reported. As they see it, Bill S 19 appears to be a political shell game in which the casual marijuana user still ends up the loser at the mercy of an unjust law.

In that respect, S 19 is reflective of several other pieces of legislation or quasi-legislation doing the rounds of various political capitals in North America.

Recently, Arthur C. Whealy, president of Ontario's Criminal Lawyers Association articulated some grave concerns about the Senate's recommendations.

In a letter to psychiatrist Dr Lionel Solursh of the non-medical use of drugs sub-committee of the Canadian Medical Association, Whealy likens the Senate bill to "an isolated band aid which creates at least as many problems as it purports to cure."

What Whealy appears to resist most strongly is the fact the Senate has chosen to confront the issue of cannabis possession via the back door instead of facing it squarely and legislating the decriminalization by the simple means of repeal of the offence at it stands.

It appears the Senate wants to have it both ways — to have the law, but to be able to suspend its effects whenever the court or the government finds it expedient. Of course there are precedents for this kind of procedure — Canada's hanging laws being the most obvious.

Whealy is also "shocked at the suggestion that every person who is convicted of a possessory offence should go through the criminal process to find out whether or not he is entitled to either a conditional or an absolute discharge, and if so, that the statute then treats him as a Pardoned Prisoner."

This kind of legal ambivalence seems to be extremely risky.

For example, two marijuana users might be accused of identical behavior, but it would really depend upon the whim of the judge as to the legal result.

One might walk out of the courtroom a free man with no record, the other with a conviction.

There are those who might argue that the conviction is academic since the individual is discharged and doesn't have to serve time or pay a fine.

Perhaps. But what does a discharge or pardon represent except that someone or some institution was "magnanimous" enough to excuse a criminal offence? The fact is, there is still an offence recorded and that offence is a criminal one.

But a pardon was historically meant to be a rarity. It was used as a safety valve and designed to allow the monarch in person (now the Cabinet) to wipe out by executive action, a court decision where that decision though legally tenable was manifestly unfair.

"To suggest that the court system should function quite properly, but to wipe out its effect by a statutory provision on an automatic basis, is to put the legal system in contempt as well as to heighten the lucicrous view of the law which the public already holds."

There is also a very grave risk that in spite of the so called automatic pardon (which is not automatic in that the accused himself has to seek out the mechanism) if a person comes back for a second offence his previous pardon would be brought up to show, as Whealy says, "that he already had one bite of the apple".

In theory, the pardon is supposed to operate so the accused is deemed never to have committed the first offence.

"How it can be brought up as a pseudo past conviction so as to influence his sentence on the second offence is quite beyond the realm of both legal and philosophic logic."

But perhaps the most slippery item in coming to grips with decriminalization of marijuana possession is that the dropping of all sanctions somehow implies a seal of approval, a green light to use.

It forces the parent to rebut the argument: "Come on now Dad, would the government make it legal if it was dangerous?"

Of course, that can be argued nicely, using such potential killers as alcohol and tobacco as evidence, but it is still a rebuttal, and the defensive team doesn't usually score the points.

This kind of argument has presented social policy planners with a dilemma. . . how do you relieve the sanctions while still retaining the concerns? How do you avoid jail penalties for casual smoking of pot without relinquishing your right to punish the commercial trafficker?

Whealy joins many before him in urging the flexibility inherent in food and drug regulations. The Food and Drug Act does not make possession of a controlled drug an offence, and cannabis could simply be added to that Act.

A second regulation could then be added making possession of cannabis a summary conviction offence for "breach of a regulation" providing that conditional and absolute discharges, fines and probation — not jail — be employed as penalties. A rider could also be added defining that conviction under this particular section is not a criminal record within the meaning of the Criminal Records Act.

This would proclaim to the public that although cannabis was a health hazard, it would not be a criminal offence to possess it. And because it was a health hazard its use would be punished in a regulatory way, similar to other substances considered equally undesirable from a health point of view.

Whealy, by implication, makes the point that there is more to cannabis than the pharmacology of the drug. How society responds to the symbol is important.

"We are definitely in favor of reduced penalties concerning cannabis. But we definitely do not like to see the law miscast and twisted to achieve a political purpose when in fact its net effect is to diminish further respect for the criminal law both within and without the profession."

By Wayne Howell

THE SHAPE OF THINGS PAST (A CHRONOLOGY OF DRUG EDUCATION)

1965-71: 'Substance-oriented' drug information programs are researched, developed, packaged, and introduced into high school curricula. Wise personal choices will surely follow.

1972-73: The personal choices turn out not to be so wise! Some substance-oriented courses actually have the paradoxical effect of encouraging experimentation.

1974: Back to the drawing board.....

1975: The concepts of 'value-reinforcement' and 'positive self-image' are born. Non-MUD unveils project 'vegetable farm' for 6 to 9-year-olds. Eggplant, Radish, and Mr. Cabbage lead the way in developing self-confidence and self-esteem. Wise personal choices will surely follow.

THE SHAPE OF THINGS TO COME

1976: Child psychologists point out that all research in the last decade suggests that a child's intellectual and social skills are formed before the first two years of life. Differences in ability to cope with life-trauma are evident by three years of age.

1977: 'We will educate them in the classroom, we will educate them in the play-school, we will educate them in the crib, we will educate them in their diapers — we will never give up!', declares a non-MUD spokesman at a press conference announcing a new line of non-MUD developed anti-drug toys for toddlers and anti-drug mobiles and soothers for cradle-bound tykes.

1978: Child psychologists point out that it is the mother or mother-surrogate figure that plays the crucial role in the formative years; she has to make wise personal choices re tactile stimulation in the neo-natal period, and wise choices re exploration encouragement in the critical 10 to 18 month period, or the child's intellect and social skills will be inadequate and he will be handicapped in his ability to make satisfactory progress in kindergarten value-reinforcement seminars.

1979: Four Toronto schools announce 'Maternal-Motivator' courses, to train pregnant women how to be the kind of mothers the psychologists say they should be to produce neonatal IQ-stimulated tots capable of getting the most out of non-MUD toddler-toys.

1980: Psychologists point out that the most important thing is that post-adolescents make wise personal choices in their selection of mates so they can provide the kind of stable loving environment in which the mother can maximize neonatal educative modalities to prevent drug abuse.

1981: 'Total-life Preparation' information programs are researched, developed, packaged, and introduced into high school curricula. Wise personal lives will surely follow.

state capitol and in Washington, this multi-billion dollar industry flooding the public media with advertising, has convinced the American public that increased consumption is not responsible for increased human and economic loss.

Truth is truth. Preventive efforts of education and promotion of responsible drinking have not worked — except where per capita consumption is held down. If education were the answer to our problem we would not have alcoholic medical doctors. They are well informed of the drug effect on mind and body.

Richard E. Taylor, Jr.
Kansas For Life at its Best
218½ West Sixth Avenue
Topeka, Kansas 66603

Sine qua non

Sir:

I am writing with two purposes in mind.

First, I would like to thank you very much for your coverage of the proceedings at the Fifth International Conference of the International Association for Accident and Traffic Medicine and the Third International Conference on Drug Abuse of the International Council on Alcohol and the Addictions (**The Journal**, October). I believe that through its coverage of such events your journal sets a pattern which will become the sine qua non of good journalism in this field.

Second, considering the length of time the discussion went on, most of the reporting on my talk in this issue is remarkably accurate. I should like to point out that the seven-day "think tank" which Anne MacLennan noted that I attended several years ago was held not in Germany but in Sevres, France. The aim of the Sevres Conference, which was sponsored by the United Nations Educational, Scientific and Cultural Organization (UNESCO), was to provide an opportunity for the exchange of ideas and information among delegates from the industrialized nations. It was there that I learned about the important experiments in Germany to which she alludes.

Beny J. Primm, M.D.
Executive Director
Addiction Research and Treatment Corporation
Brooklyn, New York 11201

"Sorry Ma'am – no pot. . ."

(The Journal, July, 1975)

Sir:

The stereotyped portrayal of the woman in this cartoon (above) is offensive to women, and not only is unnecessary to the cartoon's content but also detracts from its impact.

We hope that in future **The Journal** will avoid using sexual stereotypes as a source of humor.

C. Michell
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B. McKay
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Deloris Yezerski
Connie Schmidt
A. R. Wright
R. W. Nutter
Alberta Alcoholism and Drug Abuse Commission

European drug trafficking

New control network

By THOMAS LAND

PARIS — Cabinet ministers of the nine-member European Common Market and Sweden, have established a new permanent organization to restrict drug trafficking on the continent.

The decision, taken at a conference here of ministers of health and education and secretaries of state from the 10 countries, follows important new developments in the illicit trade of drugs which recently turned Amsterdam, that liberal Dutch city much loved by North American tourists, into the contraband capital of Europe.

The new European Drug Cooperation Group "will be essentially concerned with repression," M. Michel Poinatowski, the French Minister of the Interior, told correspondents after the conference.

"It will be an organization with permanent national representatives based in Paris. Each member nation will designate specialists to ensure speedy and systematic communication on all relevant information concerning drugs, traffickers, and means of prevention."

He said about 90% of the drug users arrested in Europe are aged under 25 years, and stressed the importance of explaining the dangers of drug abuse to young people.

Most of the hard drugs now reaching the illicit world markets originate in the Far East and Latin America.

"At least two networks now exist," one expert said, "with one group smuggling one-ounce packets from Hongkong and another sending 900 gram packets from Malaya, supplying Europe along the links provided by the Chinese colonies.

"The demise of Marseilles after the smashing of the notorious French Connection to North America has seen the rise of Amsterdam as the European drug capital in terms of import and distribution.

"The latest figures show heroin seizures in the Netherlands have risen from 50 grams in 1971 to 28 kilos in 1974, and the number of known addicts has risen. Dutch police suspect that the supplies are being stored around Amsterdam; heroin arrives by air in neighbouring countries and enters overland."

A spokesman for the Geneva-based International Narcotics Control Board of the United Nations comments: "The magnitude of the seizures reported by the Netherlands authorities is sufficient proof of the serious nature of the traffic. The task of the Dutch law enforcement services is made all the more difficult by the number and extent of the international communications links through the country."

Holland has adopted liberal policies on cannabis. "There can be little doubt," says the Narcotics Control Board, "that the ease of access to supplies of cannabis draws consumers to the Netherlands. This movement is extending to other dangerous substances as well, such as heroin and LSD.

"The Netherlands authorities are not alone in their concern about the situation, which is causing alarm in several neighbouring countries. While we are confident that the Netherlands authorities will do all that is necessary, the Narcotics Control Board has decided to keep the problem under permanent observation."

The cannabis trade has grown with the youth cult, moving from an amateur to a professional basis of operation and attracting traffickers from other drugs.

Morocco, Lebanon and Pakistan supply Western Europe, with plenty to spare for the North American market via the Atlantic sea and air ports of the Common Market. The growth of trade is illustrated by single finds which have recently increased from consignments of 50 kilos to something approaching a ton.

The new European organization will be much concerned with exchanging information on the latest techniques of smuggling as well as means of detection. The pace of detection has already quickened with the growth of international cooperation as shown between the American and French authorities. The basic weapon remains long-term intelligence and specialist filing systems.

Piecing together apparently unrelated information can lead to priceless intelligence such as the use of innocent European tourists as couriers by smugglers. Often their cars are stolen in some Middle Eastern or Mediterranean countries, to be recovered by local police a day or two later. Unknown to the owners, their cars can be "fitted up" by a smuggling ring which welds metal containers of contraband to vehicles or packs them into door panels.

Back in Western Europe, the cars are stolen again a few days after their arrival, by other members of the same gangs recovering the drugs in relative safety.

Around

Alcohol boosts Czech juvenile crime rate

By JOHN DORNBERG

MUNICH — Nearly 40% of all juvenile crimes in Czechoslovakia are committed under the influence of alcohol.

This was the conclusion reached at a two-day seminar on the problems of juvenile delinquency held recently in the Czech spa town of Karlovy Vary.

The conference, held to coordinate the work of various ministries and government agencies involved in combating "harmful influences" upon children and youth, devoted special attention to the problem of alcohol abuse among the young.

Concurrently, the most recent issue of *Sociologia* (June 1975), a bi-monthly of the Slovak Academy of Sciences, has disclosed figures and studies on alcohol-related crime, in particular among youths.

These show there has been a 250% increase in juvenile delinquency in the five-year period from 1968-1972, following the era of liberalization under Alexander Dubcek and the subsequent Soviet invasion and occupation.

The silent enemy, to judge from the Czechoslovak studies and discussions, appears to be alcohol whose consumption has been rising steadily despite anti-alcohol campaigns.

Czechs, who prefer beer, and Slovaks, whose preference is wine, consume almost nine litres of pure alcohol per capita annually.

In 1973, the last year for which complete statistics are available, Czechoslovaks spent 17.5 billion koruny (about $3 billion) on alcoholic beverages and nearly 40,000 people broke the law under the influence of alcohol.

In the Czech republic, according to one recent report of 968 crimes of violence committed by 15- to 18-year olds in 1973 and closely examined by sociologists, 369 were committed under the influence of alcohol.

A series of police raids conducted in Central Bohemia last fall resulted in the charging of a number of restaurant and tavern owners on charges of serving alcohol to minors.

Radio Prague reported this spring that the fight against alcohol abuse is "not easy" when stores "are full of bottles of alcoholic beverages and catering enterprises do everything to promote the sale of alcohol".

Czechoslovakia was one of the first socialist countries (after Bulgaria) to introduce Coca Cola and other popular Western soft drinks in the late 1960s.

But Coke, *Sociologia* pointed out pithily, is actually somewhat more expensive than beer — a fact which must also affect the drinking preferences of the young.

Help urged for vagrant alcoholics in UK

By ALAN MASSAM

LONDON — Britain's National Campaign for Single Homeless People has urged the Home Secretary, Roy Jenkins, to take action over the increasing number of alcoholics and vagrants being sent to prison.

The demand follows the release of Home Office figures showing that:

- A record 101,243 men and women were arrested for public drunkenness in 1974;
- Of these, 3,091 were sent to prison, 2,675 because they were too poor to pay their fines;
- Sixty-seven of those imprisoned were under 20 years of age;
- More than 1,000 received prison sentences of less than 14 days.

Director of the campaign, Nicholas Beacock, said that in 1974, 5,040 prosecutions were brought against homeless and poor people under "antiquated" 1824 vagrancy laws.

He said at least 506 men and women were sent to prison for such offences as sleeping rough (out in the open) and begging on the streets.

"These alarming figures are a further indictment of society's failure to provide homes and care for thousands of men and women for whom prison can offer no solution," Mr Beacock said.

"With the prison population reaching the danger point of 42,000, Mr Jenkins must act now to halt the relentless flow of alcoholics and vagrants into prison. It is a pointless waste of public money.

"Mr Jenkins should take two steps. First he should abolish the laws that punish alcoholics for their illness and vagrants for their homelessness. Second, he should demand of his colleagues that the Secretary of State for Social Services and the Secretary of State for the Environment set up treatment centres for alcoholics."

*Campaign for Homeless and Rootless People, 27 Endell St., London WC2, England.

100,000 young German drinkers

BONN — Ten percent of West Germany's one million alcoholics are under 25 years of age, according to the federal health ministry.

The figure was disclosed by a ministry official during a recent parliamentary question hour.

"We must assume that approximately 100,000 alcoholics are youthful," the official said.

The Federal Republic recently revised upward its estimate of the total number of alcoholics from 600,000 to "approximately one million".

The official also disclosed the government has earmarked DM 20.5 million (about $9 million) in the 1975 budget for the fight against alcohol and other drug addiction.

Alcohol-makers vs anti-alcohol forces

the World

French campaigners clash

By LYNN PAYER

PARIS — When France's major producers of aperitifs and spirits announced last year that they were starting a research institute to help combat alcoholism — "the cancer of the profession", established anti-alcoholism forces were skeptical. (**The Journal**, November 1, 1974)

They adopted, however, an attitude of watchful waiting.

Last spring, shortly before Paris disbanded for the summer, the new agency, Institut de Recherches Scientifiques, Economiques, et Sociales sur les Boissons (IREB) announced a public information campaign, supposedly to combat alcoholism. And this fall, as Paris began functioning again, the Comite National de Defense contre l'Alcoolism launched its attack on the campaign.

One IREB project was distribution of a cardboard calculator enabling a driver to estimate his blood level of alcohol as a function of the number of glasses consumed, weight, and sex.

The other project was widespread diffusion of a slogan: *Pas plus de sept verres par jour. Comptez vos verres.* (No more than seven glasses a day. Count your glasses.)

The seven glasses a day limit was based on recommendations by the French Academy of Medicine that a maximum of 3/4 litre of wine at 10 degrees should be consumed daily, and that this represents 7.5 centilitres of pure alcohol.

IREB figures that the more concentrated the alcohol is, the smaller the glass. So, a glass of wine, aperitif, or spirits contains approximately the same amount of alcohol, 1 centiliter.

Consequently, according to the IREB press release: "Seven glasses (of whatever) a day, for a man of 80 kilograms, are an acceptable maximum, this norm being slightly less than that set by the Academy of Medicine."

The problem, as the Comité National de Defense contre l'Alcoolism pointed out at a recent press conference, is that the qualification "80 kilogram man" tends to fall out of the slogan, leaving only "seven glasses a day".

"What about men of lesser weight, women, young people, people with certain diseases, ex-alcoholics? The formula becomes 'seven glasses for everybody'."

In addition, Dr Jacques Godard, General Delegate of CNDCA said the Academy of Medicine recommendations have been taken out of context.

In reality, the 1916 text endorses a limited consumption of wine, beer, or cider with the meal, but condemns habitual use of aperitifs which of course, as makers of aperitifs, the sponsors of IREB are trying to promote.

While IREB's other project, the distribution of the cardboard calculator, NORMALCOOL, does take into account weight and sex, and may be a useful approximation of the alcohol blood level, the anti-alcoholism groups maintain that any driver who relies on its advice is liable to get into trouble.

On the purely technical level, there is the question of how much alcohol a glass contains, a question pertinent also to the slogan.

The slogan was figured on the basis that each glass contains eight grams of alcohol; NORMALCOOL states 11 grams of pure alcohol per glass; and Professor J. Lereboullet of the **Institut de Alcoologie** 12 grams.

In addition, while the equivalence among glasses probably holds true for what is served in cafes, glasses used at home may well be more generous.

"But the most important criticism . . . is that it doesn't take into account the very important individual variation where alcohol is concerned," said Professor Lereboullet.

Individual variation is so marked, he said. With the same dose of .60 grams of alcohol per kilo in men, and .50 grams per kilo in women, the mean blood level is 0.59 g/1 but the range is from .22 grams per liter to .94 grams per liter.

Consequently, with a dosage that on the average gives a blood level of 0.59, approximately 13% of people will have a blood level above the legal maximum in France of .80.

These facts are mentioned in small print on the back of the calculator. In even smaller print there is a warning, in rather convoluted language, that NORMALCOOL indications have no legal value.

Although CNDCA considers IREB's information campaign particularly insidious because it is masked as science, they are not particularly surprised by it.

The working hypothesis of IREB is that there is a clear line of demarcation separating the alcoholic and non-alcoholic. Its stated aim is to define more clearly this difference, thus allowing the non-alcoholic proportion of the population to increase its alcohol intake in this, the country with the highest per capita alcohol consumption in the world.

As Dr Pierre Fouquet summed up the strategy at the CNDCA press conference: "They are trying to inform this mass of potential consumers of their biologic rights: 'Science is telling you, you have the right to more alcohol. Have confidence in us, we will help you.' "

TOP O'THE HOPS

Britain's beer drinkers quaffed 11,094 million pints of ale last year — the highest figure for any 12-month period this century. The 1974 figure translates into 38,520,054 barrels, an increase of about 1½ million barrels or 435 million pints over 1973.

ABSINTHE FRIENDS

Researchers in Puerto Rico have found that wormwood, the ingredient used for flavoring absinthe, contains a chemical called thujone which has a molecular structure similar to that of tetrahydrocannabinol (THC), the active ingredient in cannabis. Absinthe, long a favorite of many drinkers, has an alcohol content of 70% by volume and has been known to cause hallucinations.

AA GOES PUBLIC

For the first time in its history, Alcoholics Anonymous has been holding public meetings in Scotland. A series of meetings was held in towns all over the country earlier this year in an effort to arouse public awareness of alcohol problems and to bring together alcohol experts from the medical, psychiatric, spiritual and social fields.

BIRCH TREATMENT

Libya has prohibited drinking, selling, possession and making of alcohol in accordance with the principles of Islam. Muslim or non-Muslim offenders will be liable to between 10 and 40 strokes of the birch.

BROMIDE DEATHS

There has been a dramatic increase in acute bromureide intoxications in West Germany in recent years, says a University of Gottingen study. In some centres, more than half of all poisonings with hypnotics are being caused by this group of drugs — the new versions of old bromide solutions used in treatment of epilepsy. Austria and Australia report similar developments.

Monkey 'pecking order' changed by marijuana

Ethel Sassenrath with drugged monkeys

DAVIS, CAL. — The only effect a daily 20-joint dose of marijuana seems to have had on some monkeys at the California Primate Research Center here was to increase their "irritable aggression".

Dr E. N. Sassenrath, who has supervised the research at the centre, which is a part of the University of California, has reported that no drug-related changes were found in the levels of stress hormones, the sex hormones, or in cellular immunological responsiveness.

In fact, she said, one of the drugged males sired offspring and several of the drugged females gave birth to "grossly normal offspring' and nursed them for six months.

Changes were however, observed in the social behavior of the drugged monkeys.

The initial response to the daily drugging was sedation, she said. Drugged monkeys showed a mark decrease in competitive behavior and interaction with non-drugged monkeys in the same cage.

This sedated, non-competitive response was followed by a gradual development of tolerance to the main effects of the drug and this, in turn, was followed by the subtle development of an "irritable aggressiveness" in the drugged monkeys, Dr Sassenrath said.

This change, she said, was very subtle and only detected when observers noted changes in the structure of the social hierarchy within a cage. The social hierarchy or "pecking order" among monkeys is very well defined, she added.

In one cage, the drugged female went from her undrugged position as number five, to number six, or the bottom of the social order, during the first, sedated months of drugging. She then moved gradually to number two position directly below the dominant male, said Dr Sassenrath. This female was, in fact, so aggressive toward the other two males in the cage that they had to be removed, the researcher added.

Monkeys in the cage were apparently more aware of the subtle behavior changes than the trained observers, said Dr Sassenrath. Monkeys responded to the irritable behavior either by completely avoiding or by submitting to their drugged cage member.

The study showed that behavioral changes do occur in primates at drug levels comparable to heavy use in man and that these changes are comparable to those described in rodents after heavy use and to what has been described as the syndrome of heavy marijuana use in man, said Dr Sassenrath.

She said the apathy, lethargy, and withdrawal effects could be produced at high drug dosages in naive or tolerant primates, but that the irritability was only evident in the social context after sustained, high-level exposure to the drug.

Five steps to sanity

LONDON — A former executive with a leading tobacco company who has now allied himself with the anti-smoking forces, has developed a "five-step plan for sanity".

His plan would deal with the problem of tobacco smoking by phasing it out, "by prior notice but *irrevocably* over a 10-year period".

Arthur Hayward-Costa is a management and marketing consultant who spent five years managing the advertising and promotion of leading tobacco brands in England.

"I did not once meet a tobacco executive of any consequence (including myself) who felt any sort of guilt in the job we were doing.

"The public are just incidental profit-fodder that has to be coaxed and exploited to produce the right results for the annual general meeting."

His plan would work as follows:

By 1977: Banning of all sports sponsorship and similar "back-door tricks";

By 1979: Strict control by legislation of advertising and promotion;

By 1981: Strong measures to reduce the number of tobacco-selling outlets;

By 1983: Total ban on advertising and promotion and high taxation;

By 1985: Sale of tobacco products at drug stores only, by coupons.

His plan, he writes in a London Sunday newspaper, "would give everyone now profiting or needing tobacco revenue exactly ten years in which to find alternative sources of money".

For now, he says, even the established and vocal anti-smoking groups have little idea and much less money effectively to curb the production, sale and promotion of cigarettes "so professionally and relentlessly marketed by experts".

A PROFILE OF DR DONALD GOODWIN

'The case for research is incontrovertible . . . at this point we don't know what we're doing.'

...by HARVEY McCONNELL

NEWSPAPERS AND writing have always played a significant role in Donald Goodwin's career and life.

While growing up in Parsons, Kansas, he spent his spare time working on the small daily his father still publishes.

Income from a weekly syndicated column, which he wrote for more than a decade, enabled him to live the good life for four years in New York City and then made medical school comfortable when, at age 31, he decided he wanted, after all, to be a doctor.

It was a newspaper clipping that led him to his most widely publicized and continuing investigation — a collaborative study with the Danes on the question of a genetic basis for alcoholism.

Dr Goodwin is professor of psychiatry at Washington University, St Louis, director of the Clinical Addiction Center there and was one of the two 1974 winners of the E. N. Jellinek Memorial Award for outstanding contribution to the study of alcohol problems.

The newspaper story that lead to his Danish work was about a study of schizophrenia by Dr S. K. Rosenthal and colleagues. The study was being carried out in association with Danish psychiatrist, Dr F. Schulsinger, and they were using as a base the central register in Copenhagen which contains records of all psychiatric hospital admissions in Denmark over the past 50 years.

Schizophrenia, like alcoholism, runs in families and eventually Dr Goodwin, with Dr Schulsinger, initiated their current study of adoptees who had a biological parent who was an alcoholic.

It has been known for years that alcoholism is a familial disorder but not whether it is due to genetics or environment.

Data from the Danish study show that children of alcoholics brought up by non-alcoholic foster parents have a much higher rate of alcoholism in adult life than adopted children whose biological parents were not alcoholics.

Everything possible has been done to eliminate bias.

Dr Goodwin says: "If there had been a bias I would have been concerned about the results because, frankly, they are a little too neat for me. I did not predict the results and I did not expect them."

He has no idea what the computer will show when the latest data, this time on the daughters, are run through later this year.

As there is now so much research into alcohol, and as he has been on both sides of the fence, Dr Goodwin sees clearly the conflict between reporting scientific fact and the often preliminary reports that result in newspaper scare stories about alcohol doing damage no one suspected.

He points out: "Human epidemiological facts are not, in general , that scary, in the sense that alcohol is used by an enormous number of people. While it certainly increases certain risks nobody will deny — liver disease or accidents — some of the other associations have to be looked at very critically.

"Life is a lot more complicated than, say, the deleterious effects of alcohol on the brain, liver or heart muscle — you name the organ and it has a deleterious effect.

"The study of alcohol has become what the study of syphillis used to be: You are bound to find something 'showing' a dose risk of alcohol on anything. But I am saying that a lot of these are not demonstrated.

"The actual hard evidence that is really beyond question of an association between normal use of alcohol, I mean something short of alcoholic drinking, and damage to the body, is scant.

"In the case of alcoholic drinking, it still remains a question of whether ethyl alcohol is specifically doing the damage or whether the damage is resulting from a whole variety of factors.

"All the brouhaha over 'what is an alcoholic?' or 'who is an alcoholic?' overlooks what occurs not only with alcoholism but also with other disease, the grey zone, and it is a shifting thing. For example, people still cannot make up their minds what is normal blood pressure for a man in his 60s."

Dr Goodwin has no time for those who think they have the answers as to why some people have trouble with drugs. "The fact is, and I believe this fervently, nobody has the answers.

"I think that is what divides most of us who want the money spent on research as opposed to most of those who want the money spent on education and service.

"To educate and help people you need to know what you are doing and at this point I don't think we know what we are doing. I think the case for research is incontrovertible."

By definition research is a gamble as well as a long term effort. He would like to see research spending tied to the gross national product with the hope that results will be produced, eventually, to help future generations.

Dr Goodwin observes that one of the major, still unanswered research questions is whether there is a susceptibility to drug abuse, including alcohol — whether the choice depends on availability and cultural factors, or whether there is some specific vulnerability to a specific drug.

This effort can start "with something that we can more or less agree with other people is real.

"I think it is real, for example, that alcoholics can drink more than non-alcoholics without getting sick. This could be described as the lack of intolerance because there are countless people, maybe a majority, who can't drink beyond a certain amount without suffering dire consequences.

"How does this develop? I say that at least they are born with a lack of intolerance and this could come within the definition of a specific vulnerability to alcoholism."

There could be other specifics: The literature is mixed and confused on the effect of alcohol on brain amines. Alcohol has both the anesthetic and euphorgenic effects and the chemical basis for euphoria is unknown.

"I think it is real that alcoholism runs in families. That doesn't mean that it is inherited. I don't know.

"I think we have some evidence suggesting certain severe forms of alcoholism may be transmitted independent of post-natal experience."

Looking back over the past decade Dr Goodwin assesses his work frankly: "I am not being unduly modest when I say that I don't really think that other than leads and suggestion and clues, I have come up with anything that is going to lead to a trip to Stockholm! The quantity has been satisfactory but the quality has been uneven, to be honest about it. But I expect that."

As for the future: "There are not any new ideas. It is just a matter of taking the few handles we have got and doing the best we can."

New Books

by RON HALL

The Benzodiazepines — Patterns Of Use

Compiled by C.E. Weise and S. F. Price
Addiction Research Foundation
(33 Russell Street, Toronto, Ontario. M5S 2S1), 1975
210p.: $7.00

This annotated bibliography contains the full citation for 248 references in the English language which have appeared in the literature during the past 15 years. Epidemiological surveys, prescription data studies, literature reviews, letters to the editor, and commentaries are included. The work is fully indexed using 37 key words and an author index.

Coping With Drugs: Rational Response To Their Use

. . . by Gordon Matthews and Sue James
The Cyrenians Limited
(13 Wincheap, Canterbury, Kent CT13TB), 1975
index: 70p.: 75p.

This indexed book is aimed at providing practical information on drug use and abuse for the layman. Prescribed and commonly abused drugs are presented and specific details including dosage, side effects, overdose symptoms, dependence, and withdrawal are outlined. In a final chapter, the authors deal with legal problems, treatment problems and particular issues related to houses for the homeless.

Alcoholism: A Social Disease

. . . by Max Glatt
St. Paul's House
(General Publishing Group, 30 Lesmill Rd., Don Mills, Ontario. M3B 2T6), 1975.
index: 239p.: $2.75

In this new revised edition, Dr. Glatt explains how alcoholism arises and how it may be treated. He provides a review of the social aspects in an effort to promote a basic understanding for the alcoholic and those who come into contact with alcoholism.

Library Book Catalogue

Law Enforcement Assistance Administration,
Drug Enforcement Administration,
Federal Bureau of Prisons, and the National Criminal Justice Reference Service
U.S. Government Printing Office (Washington D.C.), 1975
subject catalogue, $6.00: title catalogue, $3.70:
author catalogue, $3.75: periodicals catalogue, $1.25

This set of catalogues contains the notations of the holdings of these four libraries and updates the first volume published in 1972.

Drugs: Administering Catastrophe

. . . by Graham S. Finney
Drug Abuse Council, Inc.
(1828 L Street N.W., Washington, DC 20036), 1975.
141p.: $4.00

In this report, the author relates his experiences as former commissioner of New York City's Addiction Services Agency and he presents the structure, operation, and evaluation, as well as other aspects of the drug abuse agency. In a chapter dealing with drug abuse strategy, discussions of job discrimination, multiple drug use, decriminalization, and compulsory treatment are used to provide a framework for alternatives.

Findings Of Drug Abuse Research

National Institute on Drug Abuse
(Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402), 1975.
2 volumes: index; 762p.: $12.05

This two volume set is an annotated bibliography of NIMH and NIDA — supported extramural grant research from 1967 to 1974. The work contains over 3,500 titles which have been produced by more than 650 researchers. The first volume concerns itself with the methodology of drug research and findings of basic research into the chemical and metabolic characteristics of drugs and their mechanisms of action. The second volume is devoted to behavioral and clinical aspects of drug abuse research, prevention and treatment, psychosocial studies, and epidemiology.

Other Books Received

The Multinational Pharmaceutical Industry: Levinson, Charles, I.C.F., Geneva, 1975.
Regulation and Drug Development: Wardell, W.M., and Lasagna, Louis. American Enterprise Institute for Public Policy Research, Washington, 1975, 181p., $3.
The Social Control of Drugs: Bean, Philip. Martin Robertson and Company, London, 1974, 198p., $7.45.
Essentials of Chemical Dependency: Alcoholism and Other Drug Dependencies: McAuliffe, Robert M., and McAuliffe, Mary Boesen. The American Chemical Dependency Center, Chanhassen, 1975, 267p., $4.95, pathology: symptons: causes.
Essentials of Chemical Dependency: Alcoholism and Other Drug Dependencies: McAuliffe, Robert M., and McAuliffe, Mary Boesen. The American Chemical Dependency Center, Chanhassen, 1975, 142p., $4.95, diagnosis: symptoms: instruments.
The Shaman and the Jaguar: Recihel-Dolmatoff, G. Temple University Press, Philadelphia, 1975, 280 p., $17.25.
Bill W.: Thomson, Robert. Harper & Row, Publishers New York, 1975, 373p., $8.50.
Methaqualone: A Study of Drug Control: Falco, Mathea. Drug Abuse Council, Inc., Washington, 1975, 66p.
Diagnosis and Treatment of Adverse Reactions to Sedative-Hypnotics: Smith, D.E., and Wesson, D.R. National Institute on Drug Abuse, Rockville, 1975, 68p.
Alcohol and Drug Dependence: Association of Psychiatrists in Africa. International Council on Alcohol and Addictions, Lausanne, 1975, 135p.
Student Drug Use: An Annotated Bibliography: Petersen, David M., Beer, Elizabeth T., and Elifson, Kirk W. Department of Sociology, Georgia State University, Atlanta, 1975, 55p.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings please send announcements as early as possible to The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

Substance Abuse Prevention Forum — Dec. 8-10. Omaha, Nebraska. Information: Mr. J. Kushner, Executive Director, Nebraska Commission on Drugs, State Capital Building, Lincoln, Nebraska, 68509.

Second Caribbean Conference on Strategies of Drug Abuse in Developing Countries — Feb. 1976, San Juan, Puerto Rico. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Third National Drug Abuse Conference — March 25-29, 1976, New York City, N.Y. Information: Joyce H. Lowinson, M.D., Chairperson, National Drug Abuse Conference, 1500 Waters Place, Bronx, N.Y. 10461.

International Conference on Alcoholism and Drug Dependence — April 4-9, 1976, Liverpool, England. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Seventh Annual Medical-Scientific Conference of the National Council on Alcoholism — American Medical Society on Alcoholism - April 9-10, 1976, Washington, D.C. Information: National Council on Alcoholism, Inc., 2 Park Ave., New York, N.Y. 10016, Att'n: Medical-Scientific Conference.

Sixth International Institute on the Prevention and Treatment of Drug Dependence — June-July 1976, Hamburg, Germany. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Canadian Conference on Youth, Society and the Law — June 7-10, 1976, Kingston, Ont. Information: Chairman, Canadian Conference on Youth, Society and the Law, 55 Parkdale Ave., Ottawa, Ont.

Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies — June 20-25, 1976, Toronto, Ont. Information: W. J. Gilliland, Conference Manager, Information, Addiction Research Foundation, 33 Russell St., Toronto, Ont., M5S 2S1.

11th International Conference on Medical and Biological Engineering — Aug. 2-6, 1976, Ottawa, Ont. Information: Conference Office, National Research Council, Ottawa, Ont. K1A 0R6.

Seventh International Conference on Alcohol, Drugs and Traffic Safety — Jan. 23-28, 1977, Melbourne, Australia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

International Medical Symposium on Alcohol and Drug Dependence — Aug. 21-26, 1977, Tokyo and Kyoto, Japan, Inforamtion: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Israel brandy sales down

TEL AVIV — There has been a sharp — 26% — drop in the sale of brandy in the first half of 1975 compared to the comparative period in 1974, the Vine Growers Assocation here has announced.

The association attributes the drop to the economic situation in Israel.

The sale of sweet wines dropped by 12% in the first six months of 1975, and of dry wines by 3%.

In 1974, some 4.1 million litres of brandy were sold; 3.4 million litres of sweet wine; and 8.4 million litres of dry wines.

Israel had a population of 3,200,000 then, of whom 360,000 were Arabs who, theoretically, do not drink any alcohol for religious reasons.

Frankfurt's Youth Health Centre

An adolescent 'sanctuary'

By DAVID BRACEY

FRANKFURT-AM-MAIN, GERMANY — "I seem to be getting a negative reaction from you. You're getting defensive . . . ," the doctor said with a playful touch of the Devil's advocate.

"Well, yes, maybe I am, it's just that I think you're accusing me of . . . "

The woman glanced around the room at some 20 onlookers — a couple of US Army officers in khaki, a woman soldier-secretary in pale green, men and women in civilian clothes, an Army Corpsman in white, a corporal-driver in gigantic combat boots. Altogether an unusual assortment.

This was not a T-Group — yet in a way it was. The physician, Major Ira Sacker, medical director of the Youth Health Centre at the US Military Community here, was looking for reaction to a complaint by one of the 80 to 100 teenage military dependants who daily come to the adolescent "sanctuary" with their drug, drink, sex, physical and mental health problems.

THE BACK PAGE

A girl had replied indignantly on a questionnaire that "they swore up and down I was pregnant," when she presented with dizziness, headache and vomiting.

Despite the flood of praise for the Frankfurt YHC in the questionnaire results, staffers were trying to find out about themselves, among themselves, to see whether in the main, they were doing things right.

Do they tend to over-react to somatic "flags" and see a psychiatric disorder behind every other cough or ache? Do clients, usually skipping military high school for help, really have to wait too long?

These "rap sessions", which brought one new counsellor to tears recently, are part of the group's way of determining, in the language of the generation, "where we're coming from, where we're at". The self-analysis, Dr Sacker said, is one way of assessing their own sincerity and objectivity. For example:

"People get into a bind when the word 'job description' comes up. It puts a limit not only on what they should do, but what they want to do. Here, there has never been a limit."

As well as regular staff meetings and T-groups, the YHC has a "fantasy meeting" every six months.

"It's the time when the entire staff gets together and writes down what it wants to do, to the hilt, not just medically but fun-wise and community-wise," Dr Sacker said.

This, together with the practice, as a group, of interviewing any prospective candidate, results — to the outsider's view at least — in a harmonious and affectionate team.

The YHC, now serving some 3,000 adolescents at the US Army V Corps in and around Frankfurt, was started in April, 1973, sponsored by the US Department of Defence and the White House Special Action Office for Drug Abuse Prevention (SAODAP).

It has outlived the latter and sees testimony to its worth in the fact it lives on with manpower and money from the Military Medical Command and V Corps funds.

The YHC began inauspiciously for an Army project — it didn't "go through channels". Major Sacker was put in charge by directive. That is one reason for a degree of suspicion that still persists about the YHC.

It has been called "an abortion clinic", "a birth control clinic" and even "a massage parlor" in the military community. But equally damaging was an army newspaper headline to the effect: "New Drug Abuse Clinic Opens Up" which made some parents anxious about their children using YHC.

In fact, 80% of patients have medical problems and the remaining 20% have psychiatric and drug and alcohol problems.

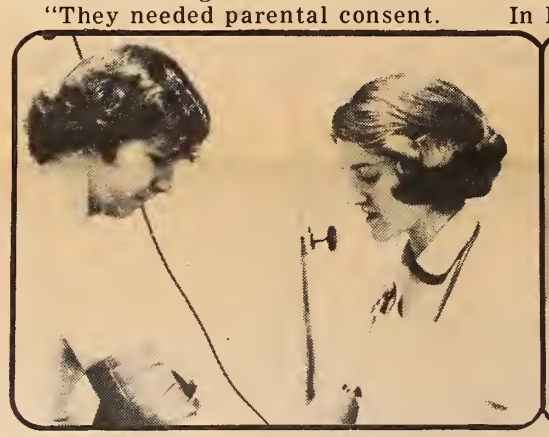
Dr Sacker believes these figures represent the true extent of the respective problems in a "normal" community. This is because the clinic has a captive patient potential. In civilian communities, he said, there are so many services and walk-in clinics, "no one really has a handle on what's happening".

The YHC is three-tiered, providing medical, counselling, and recreational facilities. An advantage here is the "back door," through which the shy people may enter to play pool in the basement, sign up for a ski-trip or, as is frequently the case, to talk about problems at home or to ask for help with a drug problem.

A key characteristic of the YHC, Dr Sacker said, is the fact it really does deal with adolescents, from 12 years up. One of the problems in the military community in the pre-YHC days, he said, as has been the case "at home", was that there was no "adolescent medicine".

"They had to go to the pediatrics clinic," he said. "Rubber duckies and that sort of thing.

"They needed parental consent. And if they wanted treatment for VD, that involved written notification to the Commanding Officer."



A patient is examined by staff physician.

The YHC, Dr Sacker said, is unique in overseas military communities in treating adolescents, with their special physical and emotional problems, as a specialty apart although at least one military hospital in the US, Fitzsimmons General Hospital in Denver, Colo., has a similar program.

Over-all director of the YHC, which began with a staff of seven and now has 21, is Dr Jeffrey Mitchell, a psychiatrist who heads a counselling staff of half a dozen.

Dr Sacker, whose hitch has ended and who will take a job as director of Adolescent Medicine at Brookdale Medical Center, Brooklyn, New York, is being replaced by Dr Mark Smith. Dr Susan Pokorny, pediatrician and psychiatrist, completes the medical staff.

Lt Ross Worch is in charge of administration and Ron Paoletti runs the activities department. There are also two full-time civilian nurses or "adolescent nurse practitioners" as they are called here, a medical corpsman in charge of supplies and liaison between the YHC and the 97th General Hospital, an Army driver, and secretaries.

Dr Mitchell stresses the importance of the "whole person approach" and says it's the "cornerstone" of working with young people. "An adult can handle the bureaucratic approach. Kids are a little more reluctant.

"They are not sophisticated enough to go through it.

"The YHC is able to minimize ferrals to other services," he stressed. "If a kid comes in for a medical problem, and it's obvious to us he or she needs counselling or psychiatric care, the services are right here."

The YHC wants to specialize further, adding obstetrics and gynaecology, orthopaedics, dermatology and physical and occupational therapy services.

Drugs, Dr Mitchell emphasized, are not a major problem. Even so, they and alcohol need special attention in Frankfurt, as do the peculiarly "military" situations that cause their misuse.

"We follow trends back in the States," Dr Mitchell said. "We are always a little behind." One trend of course, is the return to alcohol.

In Germany, it is readily available. German authorities do not query age in most beer houses until after 10 pm.

Drugs such as heroin, LSD and the amphetamines appear to have had their day. Hashish and marijuana, the latter to a lesser extent, are still widely used but are not considered a major problem at YHC.

What is a problem, however, is Mandrax, a popular German sedative containing methaqualone and benedryl. It is the most abused drug in the military dependant community.

Until recently, Mandrax was freely available in local drug stores. Now the sources are big-time dealers and the GIs themselves.

The teenage dependants find "sopers" more convenient than the other drugs. "They realized there were too many negative possibilities," Dr Mitchell said.

Jeffrey Mitchell, director

In Frankfurt, the days of experimental poly-pharmacy are also over and a more consistent pattern has set in.

Dr Mitchell discounts the significance of the Turkish opium supply. "There was a lot of hysteria about how big a problem Turkey was," he said. With the Turkish ban on opium production, he said, Western misuse might have gone down a little, but the Asian drug market filled the gap.

"There is a conservative trend among young people in the States and here. It's a reaction to the turmoil of the 60s. There is a cynical approach to things. There isn't a profession that seems to be in favour. Of course politicians never were!"

All teenagers at YHC with drug or alcohol problems are dealt with by a counsellor according to their individual situations. The clients are told, however, that their parents must be informed.

Each client is encouraged to tell his parents himself and to invite them to the centre to talk things over. If this is not done within an agreed time, the parents are notified.

The reason for this seeming lapse in the promised "confidentiality"?

The family situation is invariably found to be part and parcel of the problem, Dr Sacker explained. "In the first two years of the operation of the centre, strict confidentiality was held, with the adolescent continuing to act out until the parents were actually contacted. When the people know the actual facts, they want their parents to know. Often the kids have difficulty making the initial approach, but they do have confidentiality in making the decision."

In the military community family stresses can be immense. Husbands spend long periods away from home, wives feel isolated in the compound and alienated from whatever local community they happen to be in.

One staff member likened the life to living in an archipelago. Another described it as "like a small, Southern town". And for the whole family there is the problem of a new posting every two years. Children are continually making and breaking friendships, beginning and leaving school.

"Unless they are strong and very outgoing," Dr Mitchell said, "there is a tendency for adolescents to have to get most of their gratification from the family."

Because of their mobility, it is difficult for them to form outside attachments.

One characteristic of army family life, Dr Mitchell said, is that sex roles are well-defined.

"In every family we have encountered here," he said, "the father has been absent at one time or another from six months to a year.

"When he comes home, he is invariably a stranger and has to reassert himself."

Unlike civilian husbands, soldiers are less inclined to help around the house or with the children, Dr Mitchell said.

Some tend to be over-authoritarian. There is a tendency among them to become cold and unapproachable, "not like the cuddly Teddybear a father is sometimes supposed to be."

As a result, social services representative Ruth Hansen observed: "Therapy is primarily concerned with family dynamics. Often an individual appears at the YHC on drugs, but that really isn't the problem."

Sixty per cent of counselling done at the YHC, in fact, involves the whole family.

Unhappy or recalcitrant kids wield special power in a military community. Not only is their behaviour eminently visible in the confined society but their transgressions go on their fathers' records.

"The kids can get their fathers sent home if they don't behave," Dr Sacker said, "and they know it. The amount of control an adolescent has in the military is phenomenal."

Loneliness, anger at being away from home, boredom, all the things that drive many GIs to distraction, rub off on the children.

Administrator, Lt Worch, the soldier in the group and who looks somewhat out of place in the psychedelic lower reaches of the centre, is a responsive participant in all the staff rap sessions.

"When he first came here he was kind of rigid," one of his colleagues said. "Everything was to be done by the book. Of course, in this situation it doesn't always work. Now we're all working together."

Lt Worch is as proud of the YHC as the rest of his colleagues are.

"The most important factor about this place," he said, "is that we have a staff of 20 who really want to be here and know what they are doing. I'm not convinced there are other places like that. I have never worked anywhere where people worked so hard to see that the feelings of everybody were well represented."

Ira Sacker, medical director — Ross Worch, administrator